

Psychiatric Clinics for Children

PSYCHIATRIC CLINICS FOR CHILDREN

With Special Reference to State Programs

By HELEN LELAND WITMER, PH.D.

Smith College School for Social Work;
Research Associate, National Committee
for Mental Hygiene

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Foreword

FROM the experience which the National Committee for Mental Hygiene has had in studying and encouraging the development of psychiatric services for children, two findings of major importance have emerged. First, the need for such service is nationwide and should be met in rural areas and small towns as well as in the larger urban centers where clinics are now mainly to be found. Second, the plans for psychiatric programs must be based on thorough understanding both of the needs of children and of varying local conditions.

Efforts to provide psychiatric service for children in non-metropolitan areas have been made in a number of states. These programs have generally been built up by the trial and error methods characteristic of pioneer work, and often local pride or other prejudice has obscured inadequacies that would otherwise have been recognized. Nevertheless the staff personnel and others engaged in the work have followed the constructive course of doing their best in the light of available knowledge and of learning by doing.

A sufficient body of experience has accumulated in these state programs to warrant the effort to draw from it practical information that may be of help in planning new programs or modifications of those already in existence. With this purpose in mind the National Committee some years ago detailed two staff members well qualified by experience in the field, Miss Winifred W. Arrington and Miss Dorothy Brinker, to undertake the collection of data relative to statewide psychiatric services for children, and it has continued to observe the experience and to study the essential changes in organization and administrative methods and the reasons therefor. The Committee is fortunate in having been able to enlist the help of Dr. Helen Witmer to analyze the material against a

background of psychiatric and sociological knowledge. In addition to presenting information obtained as indicated, this volume sets forth general principles and discusses practical questions that should be considered by clinicians, administrative officers and boards, legislators, and others concerned with the planning of psychiatric service for children.

GEORGE S. STEVENSON, M.D.

*Medical Director, National Committee
for Mental Hygiene*

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Introduction

THOSE who would promote the mental health of children through psychiatric service are riding upon a full tide. For thirty or forty years it has been rising. In that time knowledge of the emotional life of children has increased enormously, and the art of helping those who are in emotional difficulty has been greatly improved. Concurrently the public's interest in these matters and understanding of them have grown. While there is still much in our social values and institutions that makes the progress of mental hygiene difficult, it seems unquestionable that the various professions concerned with human behavior are increasingly interested in the implications which dynamic psychiatry has for their work.

So far the financial resources available have not met the need. Private philanthropy has provided most of the money for the relatively few clinics that are sufficiently well equipped to give adequate service, while state and local governments have been reluctant to undertake any large-scale work of this kind. At present, however, public health, social welfare, and educational authorities are becoming increasingly concerned about mental health problems. It seems particularly important, therefore, to consider carefully what the experience of the past thirty years has taught about psychiatric work with children, so that we may take full advantage of this current of interest and not lose the venture.

It is the purpose of this book to review and analyze the evidence. For this we must go back to the beginnings of child psychiatry in the United States, note its basic hypotheses, and trace out the various lines of its development. We must try to discover what the essential elements in an effective program of child psychiatry are, and see what have been the accomplishments and difficulties of various actual programs.

We must study the changes that have taken place in the theory and practice of favorably situated clinics and consider their implications for work outside the protected area of urban child guidance. For the challenge of the present moment is that of discovering some means by which the kind of help that is available to the few patients of the best clinics can be offered to children throughout the country. As an immediate goal, this is obviously an impossible ideal; but it does seem reasonable that the criteria for effective service as now understood should be made explicit so that an approach to the ideal can be made as rapidly as circumstances permit.

This problem has been one of the continuing concerns of the National Committee for Mental Hygiene. In 1934 a description of the theory, findings, and subsequent development of the demonstration child guidance clinics that had been established in 1922 by the Commonwealth Fund was published.¹ The book dealt with the history and policies of the (usually) privately financed, urban clinics which followed the lines of development laid down by the demonstration clinics established by the Commonwealth Fund. Concurrently with that study the Committee started upon a survey of the work and problems of clinics located outside the large metropolitan centers and financed by state governments, for it appeared that such clinics were the chief means by which psychiatric service might be made generally available. Material relative to these clinics was accordingly collected for several years by Winifred W. Arrington and Dorothy Brinker, and a book about the findings was planned.

In the meantime two perhaps correlated changes were taking place. On the one hand, child guidance in both its psychiatric and case work aspects was being rapidly transformed from a rather common-sense approach to children and their

¹ George S. Stevenson and Geddes Smith, "Child Guidance Clinics: A Quarter Century of Development," New York, The Commonwealth Fund, 1934.

problems to a highly technical profession whose practices were based upon well-articulated theories. On the other hand, what had at first been a rather vague expectation that state governments would in one way or another gradually expand their psychiatric services for children assumed more positive form with the Federal Government's interest in child welfare and mental health problems. It seemed important, therefore, to do something more than survey the practices and experiences of state-supported clinics, for many of the practices seemed already outmoded and not to be recommended for duplication by new mental health programs. Instead, it appeared that the time was ripe for a new review of the history and theory of clinical child psychiatry, one that would moreover give attention to a rather neglected aspect of the question—the cultural prerequisites of a successful mental hygiene program.

The survey material was used, therefore, to elucidate one segment of the complex pattern that must be visualized before the requirements of an effective clinic system can be understood. It was supplemented, on one hand, by an analysis of the underlying philosophy, cultural prerequisites, and antecedent history of clinic work and, on the other, by a close consideration of what recent theory and practice have revealed. It is perhaps unnecessary to emphasize, therefore, that state clinics are described in this book not in order to complete a historical survey or to give a census account but in order that we may learn from their varied experience in psychiatric work.

GENERAL PROBLEMS OF PSYCHIATRIC SERVICE FOR CHILDREN

American psychiatric service for children has followed two main lines of development. One represents an extension of the extramural activities of institutions, particularly mental

hospitals, to include children—first, the defective and “pre-psychotic,” and later all who might be looked upon as potential institutional patients. In some states this work has been taken over by departments of the central government, but the prevention of mental disease tends to remain the objective since the clinics are frequently under the direction of the department that also supervises the mental hospitals. The other line of development is that of the urban child guidance clinic, usually privately financed, which aims to conserve mental health. While the distinction is not absolute (some public schools, for instance, maintain child guidance clinics, and some private hospitals give clinical psychiatric service that is much like that usually offered under state auspices), by and large, public and privately supported clinics tend to differ considerably in many important respects. The child guidance clinics usually serve a limited urban area and can restrict their intake. They are interested in treatment as contrasted with diagnosis, and in that work they employ a group of clinicians instead of relying, hospital-fashion, chiefly on the psychiatrist. In contrast, the hospital and state-administered clinics are usually set up for diagnostic service. As public institutions, most of them accept all comers as patients. Many operate in rural areas, where they must divide their time among many small communities. Their staffs tend to be less specifically trained for work with children, and much of the administration follows the lines of hospital tradition.

Attempts to adapt the theories and methods of the urban child guidance clinics to a state program therefore meet many problems, some of them inherent in a non-metropolitan situation—the lack of trained personnel and financial resources, lack of supporting community services, and, perhaps, even of attitudes on the part of the public that favor child guidance work—and some of them growing out of psychiatry’s own history and diversified interests.

For psychiatry, like other arts and sciences, is not a single, universally accepted body of theory and practice. Instead, there are several schools of thought whose hypotheses regarding the nature of mental functioning differ radically and lead to diverse attitudes and practices with respect to the selection of patients and their treatment. One group, for instance, in dealing with mental disorders thinks in terms of diseases of specific organs; another sees habit disorganization as an important element in the problem; while a third proceeds from a theory of instincts and accompanying emotions. In studying the activities of any particular program of child psychiatry therefore, the nature of its basic assumptions must be taken into account, for the types of children that are sought as patients and the services rendered to them are logical—if not always deliberate—derivatives of a theory of psychiatry.

In studying the work of psychiatric clinics, attention must also be paid to the assumptions and attitudes about human nature that predominate in the communities in which the program is being carried on. Child psychiatry is peculiarly dependent upon cooperation from both lay and professional groups for the carrying out of its therapeutic procedures. Even when this does not take the form of aid in effecting environmental changes for the patients, there must be a certain extent of cultural harmony between psychiatrists and the rest of the community if children are to be helped to adjust to life there. This is the basis for the "education of the public" which is a standard part of most mental hygiene programs. More subtly, the need for a common outlook pervades all psychiatric endeavors, and the lack of it accounts for much of the dissatisfaction which psychiatry encounters in dealing with both lay and other professional groups. Exact data on this subject are almost impossible to procure, and reliance must be placed instead on meager suggestions and general

knowledge about American life. Nevertheless, this aspect of the problem cannot be disregarded, for in the concurrence of psychiatric aims with a community's desires probably lies the explanation of many successful child psychiatry programs.

To keep in mind these two variables—the theoretical assumptions of a given psychiatric program and the culture of the community in which it operates—and at the same time pay due regard to the specific methods that are used and the personal idiosyncrasies of the administrators is obviously an impossible task, even if all the needed data were available. Yet it is upon such intangibles as these that the success or failure of a psychiatric clinic depends. It is clear at the outset, then, that our analysis of the clinics' work will result in no clean-cut evaluation. All that can be hoped is that some of the reasons for relative success or failure will emerge, and that, from the study of past and present experiments and theories, there will be findings of value to those who would set up new programs, as well as to those whose interest in mental hygiene is of a less immediate and practical nature.

CONTENTS OF THE BOOK

Since this book has a much wider scope than was originally planned, we offer the following readers' guide through its intricacies, so that those who, for instance, are chiefly interested in the changes that have taken place in child guidance theory shall not be discouraged by the mass of detail about state clinics, while those who are already well acquainted with history and theory can find more quickly our evaluation of the experience of state-supported clinics and what our recommendations for future programs are.

Part I gives the background of clinical child psychiatry in the United States. In Chapter I an attempt is made to explain how psychiatry came to the place where it considers the behavior problems of children within its area of competence.

The concepts of eighteenth and nineteenth century psychology that were incorporated into dynamic psychiatry are briefly discussed, and the main streams leading to modern American child psychiatry are noted. Particular attention is paid to the theories and activities of Adolf Meyer, for it is he, in our opinion, who exerted the greatest influence on the development of child psychiatry under state auspices. It seems particularly significant that in the early days he was closely associated with G. Stanley Hall and William James, for in their various ways these three men prepared the public to accept, at least partially, the viewpoint of later mental hygiene. Turning from Meyer, we analyze next the specific contributions which Freudian theory made to the early work of clinical child psychiatrists in this country and conclude the chapter with the observation that the agreement of these leaders that mental activity represents the adjustment of the total individual provides the basis for psychiatry's interest in the child.

Chapter II deals with the other chief element in the background of a clinic program—the ideas and institutions in American life that facilitate or hinder the progress of mental hygiene. Some of the reasons why their support is needed are discussed, and the distinction between the humanitarian and the self-interest motives is pointed out. Chapter III concludes Part I with a historical survey of the early clinics, most of which were state financed, and of the findings of the demonstration clinics, which first made child guidance a specific undertaking, and a statistical estimate of the adequacy of present clinic services.

Having discovered that the chief scarcity of clinics is found in non-metropolitan areas, we turn in Part II to an analysis of the clinics financed by state governments, for it is these which now provide most of the extra-urban service. The aim here is not to present a statistically accurate report of current conditions (for that would too soon be out of date) but rather

to describe typical experiences and modes of behavior of state-financed clinic services so that some tentative evaluation of trends and practices can be made for the benefit of those who participate in planning new programs for children who live in small towns and cities. Clinics conducted by mental hospitals made up about three-fourths of the 373 clinics under state auspices in 1935, so a particularly long chapter is devoted to an analysis of their practices and problems. Such questions are considered as at whose request they were initiated (and the bearing of that upon their reception and services), how they were introduced into communities more or less ignorant of mental hygiene (that is, some of the problems involved in what is called community education), their structure and services, types of patients, composition and training of staff, kinds of service offered (including that most baffling of all questions in traveling-clinic work—the use of local workers), and so on. This survey made it clear that there is not much in common between most state-hospital clinics and the urban child guidance ones, that the work of the former tends to be confined to diagnostic studies of feeble-minded or neurologically disabled children, and that there is little in their point of view or facilities that equips them to give help to maladjusted children of relatively normal intelligence. Two state hospital clinics that are, however, conducted along child guidance lines are described in detail in Chapter VI. In Chapter VII some of the peculiar characteristics of clinics conducted by psychopathic hospitals or state university medical schools are discussed, while Chapter VIII is devoted to the policies and problems of clinics conducted under the direct auspices of central departments of the state government.

Readers who are not interested in the detailed analysis that these chapters contain or who want to follow more directly the main argument as it was initiated in Part I are advised to go directly to Part III, which opens with a sum-

mary of the problems presented by the data in Part II and sets forth a hypothesis which is further developed in the rest of the book. That hypothesis is based on the fact that three rather divergent objectives were discovered in the work of the state-financed clinics. Its argument is that much of the apparent confusion in clinic work will disappear if the function of a clinic is clearly conceived in terms of one or another objective, and training of staff and clinic services are derived from it.

The three objectives—historically distinct but intermingled in the present thinking and practice of many clinics—are the following: to reduce the number of admissions to state institutions, to prevent psychoses and crime, to promote the mental health of children irrespective of future contingencies. Chapter X reviews in considerable detail the theory and evidence with respect to the possibility of preventing psychoses and crime through child guidance and comes to the conclusion that as a specific goal of child psychiatry this objective is untenable. Chapter XI considers what modifications in staff training and services need to be made if clinics are to help the parents and teachers of feebleminded or neurologically handicapped children to work out plans for the children's maximum development. In this connection the evidence with respect to the likelihood of being able to help these types of patients through clinic services is reviewed.

Chapter XII will probably be the most interesting to those readers who engage in psychiatric work with children suffering chiefly from emotional problems. Here the recent developments in child guidance theory are considered in a way that cuts across some of the usual lines of demarcation. The conflict between social and individual objectives in psychiatric treatment is discussed—and the theories that resolve that conflict are described. Preceding that, however, the consequences that follow from a clinic's aligning itself with other

regulative institutions are pointed out. Then some of the recent refinements in child psychiatry—particularly those elements derived in common from the work of Meyer, Freud, and Rank—are described, and their ramifications in case work with parents noted. The various means by which clinics working along these lines attempt to effect the adjustment of problem children are also considered, with their attendant consequences for the clinic's conception of its function. Finally, the implications of these recent developments for the training and duties of the various members of the clinic's staff are reviewed and reemphasized.

The final chapter attempts to draw together the numerous threads of argument previously developed and to show what pattern they disclose for clinic work, particularly under state auspices and in non-metropolitan centers. Various practical questions are considered, and if no exact answers are given it is because we recognize that conditions in the United States are too diverse to permit of drawing up detailed plans for clinic programs. We are convinced, however, that child guidance theory and experience do provide some very specific basic requirements which must be met if a program of clinical psychiatry is to be successful. Since it has taken a rather lengthy volume in which to set them forth, they cannot be summarized here.

ACKNOWLEDGMENTS

In concluding this preface to the book I should like to indicate some of the sources of my knowledge of the field, as well as to take responsibility for the sometimes audacious suggestions that I have made. It is difficult to know in what order to express my indebtedness. In the background of my preparation for the study are my ten years of experience in working with child guidance clinics and mental hospitals as a member of the staff of Smith College School for Social Work.

The psychiatrists and case workers who taught me there are too numerous to list but those who have given me the most consistent tutoring are Dr. Evelyn Alpern, Dr. H. E. Chamberlain, and Miss Bertha Capen Reynolds. My sociological approach to the problem derives from my training in that field at the University of Wisconsin and from work with Professor Bronislaw Malinowski of the University of London. Close at hand there is, of course, my indebtedness to Miss Winifred Arrington and Miss Dorothy Brinker, who collected the data on which Part II of the book is so largely based. Finally, there is Dr. George S. Stevenson to be thanked for his persistent encouragement and clarifying advice.

H. L. W.

I

The Background: Theoretical and Historical

CHAPTER ONE

The Basis of Clinical Child Psychiatry: Psychiatric Theory

PSYCHIATRY is frequently defined as the study and treatment of mental diseases, and child psychiatry would accordingly appear to be concerned with that small group of children whose behavior deviates so much from the expected that they are considered insane. Any cursory survey of the services that in the United States are offered to children under psychiatric auspices shows, however, that child psychiatry is much differently conceived. Among the patients of these clinics are to be found children who are commonly considered naughty and those who are described as too good. There are children who cannot get along in school, children who run away from home, and those who get into court because of their illegal conduct. There are children with spasms and tics and peculiar mannerisms, and there are children who are too alert and full of vitality for the crowded conditions under which they live. All these and many others are held to be the concern of the child psychiatrist, and for them the psychiatric clinic offers services that range from advice and help in modifying the environment to various forms of psychotherapy.

To explain how psychiatry came to its position of prominence in this field is a rather long story. Essentially, it concerns the development of the theory that disorders of conduct and disorders of psychic processes come from the same sources and represent the individual's way of reacting to internal and external demands. According to this theory, mental adjustment is a function of the total human being, the resultant of physiological, psychological, and situational factors, and psychiatry is "the scientific study of peculiarities of person-

ality and of interpersonal relations.”¹ That point of view represents the convergence of various lines of development, not only in psychiatry but in psychology and philosophy as well. It means abandoning the distinction between mind and body, accepting the dynamic influence of emotions on human behavior, and admitting the ineffectiveness of attempting to control an individual’s motivations by external compulsion. The practice of child psychiatry thus requires an enlightened, sympathetic public as well as an adequately trained profession, and a description of how child psychiatry came to be must take both of these elements into account.

PSYCHOLOGICAL CONCEPTS IN DYNAMIC PSYCHIATRY

This chapter is concerned with the changes in psychiatry that led to an interest in the problems of children.² The story of the development of child psychiatry must start with the time when medicine began its search for mental diseases and so took the first step toward considering psychotic individuals as something other than perverse or “possessed.” If these disorders of behavior were diseases they presumably had a beginning and perhaps a cure, and, while these were being searched for, the theory itself provided the basis for philanthropic movements looking to the improvement of conditions under which the insane were forced to live. The methods that have been employed for the cure of psychoses have not been lacking in variety:

Hydrotherapeutic, occupational therapeutic, pharmacological,

¹ Harry Stack Sullivan, “Psychiatry,” *Encyclopaedia of the Social Sciences*, New York, The Macmillan Co., 1934, Vol. XII, p. 578.

² It may seem rather academic to undertake to answer such a question, but it is our conviction that the present trends in child psychiatry can be adequately comprehended and evaluated only if the earlier history and theory are understood. Those readers who are particularly interested in this aspect of the question may find it most satisfactory to follow Chapter I with Chapter XII, for they can thus see most clearly how present child guidance theory has grown out of the past and how the earlier concepts have been adapted and elaborated to meet the patients’ needs.

organo-therapeutic, and recreational methods have vied with surgical operations ranging from modified eviscerations to injections of sundry substances into the body. . . . Patients formerly chained in dungeons and flogged; not long since exsanguinated and purged; recently drugged, isolated and restrained; still more recently treated for teeth and tonsil infections or given spinal injections of horse serum may now receive treatment by infection with malaria or have their bodily temperature raised by electrical induction.³

Some of these methods have sometimes proved helpful, particularly with the few diseases of known organic origin, but the medical profession's concentration on the search for diseased conditions has accentuated for the public the distinction between normal and abnormal. The public may have learned to view some bizarre behavior as an attribute of illness and so to include mental patients with the sick, who are to be pitied. But if the illness does not yield to therapy and no physical causes are found, the traditional medical approach provides the public with no alternative explanation for psychotic behavior.

The theory that changed this point of view and set psychiatry upon the path of studying the total human being rather than the diseases of specific organs grew largely out of psychology, although medicine itself was not always that science of laboratories and physiological experiments that has characterized so much of its work of the last two centuries. In the late 1600's, for instance, Stahl wrote:

Medicine . . . must recognize that scientific knowledge is only an instrument for the physician: it may be and often is quite alien to his art, which is the healing of the human being, and this can only be done if he understands not merely the physiological make-up of his body but the whole personality.⁴

³ Harry Stack Sullivan, "Mental Disorders," *Encyclopaedia of the Social Sciences*, Vol. X, p. 314.

⁴ Quoted by Major Greenwood and May Smith, "Some Pioneers of Medical Psychology," *British Journal of Medical Psychology*, Vol. XIV (1934), p. 176.

He held that the human organism is essentially a unit, that personal elements play a part in liability to disease, that mental conditions are important causes of both physical and mental disorders, and that emotions are more important than reason and should be taken into consideration in treatment.⁵ Since he lived in an age that exalted both reason and mechanics, his views had little weight as compared with those of his near contemporary, Albrecht von Haller, whose theory of nerve fluids and nerve irritability started psychiatry on its physiological researches.

In the meantime various concepts in psychology emerged that are basic to modern, dynamic psychiatry. Perhaps the most important is the genetic theory of personality, which holds that personality is the product of growth and experience. The earliest modern representative of that point of view seems to have been Comenius, who lived in the seventeenth century. It was later emphasized by Locke, Rousseau, and Herbart, and was carried over into the educational field by Pestalozzi and Froebel, but its full development did not come until after Darwin had made explicit the evolutionary hypothesis. Through its emphasis on origins, the theory of evolution sponsored child psychology and led to an interest in individual differences.

Closely allied with this point of view is the conception that behavior is the expression of the adjustment of the organism to its environment. This theory, too, received its chief confirmation in the elaboration of the Darwinian hypothesis, and it also has a longer history. Without pretending to trace its lineage, we can see a form of it in Locke's dictum that the infant's mind is a *tabula rasa*, that ideas are not inherent, and that experience gives the content to what the mind later knows, feels, and does.

⁵ Millais Culpin, "History of Psychology in Medicine," *Proceedings of the Royal Society of Medicine* (London), Vol. XXIX (1936), p. 1569-76.

The dynamics of the process of personality development—such an important part of later psychiatric theory—also received attention for several centuries. Hobbes put hunger, thirst, and sex as the primal impulses and considered self-interest the driving motive in life. It is of interest to note that Freud⁶ says he got the original impetus for his work on instincts from Schiller's aphorism, "Hunger and love make the world go round." Herbart, the leading psychologist of the early nineteenth century, viewed ideas as competing with each other for recognition and came close to defining a subconscious. He conceived of something akin to urges that drove men to find a meaning and purpose in experience, and through the apperceptive process he saw experience internalized. Later in the century came the numerous theories of instincts, and later still their partial rebuttal and their clarification through experiments on animals and observations of young children.

The importance of emotions in mental life is another elementary psychiatric principle that has a long history in psychology. It is seen in the theories of the late eighteenth-century German psychologists who regarded feeling, sensation, and will as the three classes into which mental states can be divided, as well as in the work of those physiological psychologists who fifty years later held that psychic life is often irrational because much of it is an outgrowth of the activities of the sympathetic nervous system. Darwin in *The Expression of the Emotions in Man and Animals* put forth the very suggestive idea that all behavior has a history, and, in general, mid-nineteenth-century English psychologists were interested in the influence of the body on the mind.

Later, in its eagerness to develop a science along the lines of physics and chemistry, psychology largely abandoned the pursuit of the implications of these theories, but at about the

⁶ Sigmund Freud, *Civilization and Its Discontents*, New York, Cape and Smith, 1930, p. 95.

time that psychologists turned to physiology psychiatrists renewed their interest in psychological questions. Actually, that interest had never wholly died but its eighteenth-century expression in the work of Mesmer was such as to confirm sceptics in their distrust of all vitalistic theories. Charcot, however, was not dissuaded, and out of his researches and their refutation by Bernheim interest in the study of hysteria and the possibility of using suggestion as a therapeutic method developed. Later Janet developed his theory of dissociation of consciousness, and Dubois and Déjerine proposed a method of therapy based on persuasion, exhortation, and explanation. It was, therefore, in an intellectual atmosphere somewhat favorable to psychological explanations of human behavior that Freud began his work, and though his theories aroused great antagonism among both physicians and psychologists they were not so spontaneous and independent a creation as is sometimes thought.

In America, in the early 1900's, there were three main groups of psychiatrists interested in psychological questions. One group followed Freud, who out of his studies of hysteria and other neuroses had come to the conclusion that psychopathological symptoms have meaning and that mental disorders signify "failure on the part of the ego to deal in any final manner with certain fundamental intra-psychical conflicts that are the inevitable lot of every human being."⁷ William A. White, Smith Ely Jelliffe, and A. A. Brill (who introduced Freud's theories to the other two) were the chief proponents of this point of view. The second group that called the attention of psychiatrists to psychology included Boris Sidis and Morton Prince. They developed, more or less independently of Freud, principles of the subconscious and experimented with the use of hypnosis in therapy. Prince held

⁷ Ernest Jones, "Psycho-Analysis and Psychiatry," *Mental Hygiene*, Vol. XIV (1930), p. 393.

that the form and development of neurotic symptoms were functions of the total psychic life; and Sidis attributed the cause of later mental difficulties to the environmental conditions of childhood. Both were opposed to many of Freud's theories. By many, Sidis and Prince were considered eccentric individualists, and their work was carried on largely outside the main stream of hospital psychiatry; but their writings could not be ignored, and it seems indisputable that they helped to arouse interest in the motives and feelings of the individual patient.

The third group was headed by Adolf Meyer. His point of view was less theoretical than the others and put much stress upon "common sense"—a fact that may account for the more ready acceptance which his work received. However that may be, it is clear that it was he who was chiefly responsible for turning American hospital psychiatry away from physiological studies to an interest in the total human being. In their several ways, then, these three groups of men and their followers brought to the American public some conception of the potentialities and dangers of childhood and made the further development of child psychiatry inevitable.

These groups and their theories are variously evaluated today. Freud's influence has undeniably spread far beyond psychiatry, while the findings of Prince and Sidis have lost their distinctive character in the general advance of psychiatric knowledge. Meyer has remained the dean of American psychiatry, the original source of inspiration of many workers in the field of child psychiatry, and the binding link between diverse schools of thought. Since this is so, and since Meyer was directly responsible for much of the early clinical work with children in this country, it seems appropriate to continue our analysis of the foundations of child psychiatry with a discussion of his theories, his associates, and his work in that field. Against that background the distinctive contri-

butions of Freud stand out more clearly, while those of Sidis and Prince need be no further elaborated upon, since they made no contributions to child psychiatry more specific than those already mentioned.

THE THEORIES OF ADOLF MEYER

Compared with the subterranean mysteries of Freud, Meyer's point of view seems particularly suited to the American tradition. He discards distinctions between mind and body, claims to take all factors into account, exalts the science of "disciplined common sense," and bases his therapy upon habit training and re-education. There is little of systematized theory in his numerous writings but, throughout, his plea is for a study of the life history of the individual in the belief that in it will be found the causes of mental difficulty.

When Meyer came to the United States as a young man in 1892 and entered upon his work at the Illinois Eastern Hospital, psychiatry was, as he later said, chiefly concerned with the dead. Man was considered a sum of elements, neuropathology was held to be the key to the understanding of mental disease, and explanations of psychoses were on the "exhaustion, poor nutrition, and metabolism level."⁸ Freud's work had scarcely been heard of, and psychologists, under the influence of Wundt, were interested in the measurement of individual differences, in an introspection that omitted both ethics and dynamics, and in the physiology of sensations, perceptions, and associations. Meyer, like Freud, began his career as a pathologist, but even in that position he insisted upon clinical studies of patients. Describing his early point of view, he wrote years later:⁹

⁸ Adolf Meyer, "Thirty-five Years of Psychiatry in the United States and Our Present Outlook," *American Journal of Psychiatry*, Vol. VIII (1928), p. 9.

⁹ *Ibid.*, p. 10.

While I used the stimulating new concepts that came from a short contact with Kraepelin . . . I was not swayed into any idolatry of dogmatic nosology and away from my earlier determination to study the facts as I might find them and for the factors at work in them. . . . To me the facts of each case were more important than the assumption of as yet problematic disease-processes.

How he came to that approach, so much at variance with the contemporary psychiatry, he tells in the same paper. As a young doctor in Switzerland, he too had viewed the asylum patients whom he treated for their physical ailments as a group apart, people "not all there" and probably always different from normal individuals. It was only after his mother became mentally ill that he realized that the psychotic patient had a past in which he had been sane and in which various internal and external events might be discovered that could account for his later misfortune.

Psychiatry became real to me only when the concepts and the experiences with its facts and problems became clearer and more concretely related to life interests; and especially when I had to handle patients whom I also had known without the mental disorder and who were viewed not as mere derelicts but as persons to be readjusted.¹⁰

Perhaps it is this basis in personal experience rather than in theory and philosophy that gives Meyer's theories their direct, pragmatic quality.

After a few years Meyer left Illinois for a position, again as pathologist, at the Worcester State Hospital in Massachusetts. There he came in contact with G. Stanley Hall and, at Harvard, with William James. The three men formed the center of the "new psychology" of the nineties. Both James and Hall had studied with Wundt and brought his laboratory methods to the United States, but their personal pre-

¹⁰ Ibid., p. 21.

dilections had carried them away from the Leipsic physiological and experimental approach and into the area of biology instead. They interpreted psychology functionally. Behavior was viewed as an expression of the adjustment of the organism to the environment, and interest was concentrated upon its origin and growth. The two men were very different personally and in their fields of influence; both were probably more highly regarded outside than inside academic psychology circles. James, the brilliant, unconventional exponent of pragmatism, became, after his early years of laboratory experiments, a philosopher rather than a psychologist. Of him it has been said:

His treatment transformed both subjects (psychology and philosophy) from "mental and moral philosophy," verbal, abstract and related neither to living experience nor to the realities of nature and human nature, into specific, concrete, vital and new observations of the qualities of men and the nature of things. . . . The world we live in consequently is for James a world of change and chance, of plurality, variety and variation, of chaos and novelty and struggle. He sees the laws of nature not as eternal principles but as acquired and changing habits of things. He sees the qualities of men as variables born of chance, enabling them to live together in and with and upon their environment, or not. Every human trait operates as instrument in the individual's struggle to live; each is validated or condemned by its effects upon this struggle. The individual is the primary and fundamental factor, the *terminus a quo* and the *terminus ad quem* of societies. . . . Social like mental evolution is the flux of the selective action of the environment upon individuals and of the transforming action of individuals upon the environment. . . . Give individuality a chance, enable initiative and freedom, and life and growth are assured to society.¹¹

Hall, on the other hand, was the energetic, practical man. In his psychological work he was an ardent geneticist, a be-

¹¹ Horace Kallen, "William James," *Encyclopaedia of the Social Sciences*, Vol. VIII, p. 368-69.

liever in the dominance of "instinct-feelings" over feeble rationality, and his research in the many phases of human behavior had great influence on educational practice. He initiated child study societies, founded various journals and associations, and was the first to introduce Freud to America. He was highly regarded by the general public, that learned from his speeches, as they did from James's books, to have some appreciation for the creative potentialities of the human personality.

Meyer's point of view appealed to Hall immediately, for he had long been interested in the psychoses. As a professor at Johns Hopkins in the eighties, Hall had served for some time as superintendent of Bayview Hospital for the Insane. He had been influential in securing the appointment of one of the first pathologists to a mental hospital,¹² and at the Worcester State Hospital he had demonstrated and discussed patients for the instruction of his Clark University students.¹³ Meyer continued that work and, in so doing, stimulated the development of a new link between psychology and psychiatry, that of mental testing. For one of Hall's students who attended Meyer's lectures was H. H. Goddard, who later clarified the concept of individual differences in intelligence and carried over Meyer's psychiatric teachings into his work with feeble-minded children. There were present, therefore, in Clark University in the nineties most of the elements of what later grew into the mental hygiene movement.

It is impossible to say how much Hall and James influenced Meyer. They were at least twenty years older, and James's *Principles of Psychology* had been published five

¹² Dr. Edward Cowles, who started work at the McLean Hospital in 1889. Adolf Meyer, "Organization of Community Facilities for Prevention, Care, and Treatment of Nervous and Mental Diseases," *Proceedings of the First International Congress on Mental Hygiene*. New York, International Committee for Mental Hygiene, 1932, Vol. I, p. 240.

¹³ Adolf Meyer, "In Memoriam: G. Stanley Hall," *American Journal of Psychiatry*, Vol. IV (1934-35), p. 151.

years before Meyer came to Worcester. Hall, on the other hand, did not publish his famous *Adolescence; Its Psychology and Its Relations to Physiology, Anthropology, Sociology, Sex, Crime, Religion and Education* until 1904, almost ten years later. At any rate, Meyer found in their work much with which he was in sympathy.

Viewed retrospectively, it would seem that the efforts of the three men were a concerted attack upon the elements of American life that stood in the way of child psychiatry. James provided the philosophy that opposed the rationalistic, Puritanical tradition. Hall was the dynamic organizer and publicist in regard to the new, genetic outlook. Meyer revolutionized psychiatry and focused its attention upon the living and upon prophylaxis. With the three of them at work it would seem that the intellectual climate of America should have become very favorable to the development of mental hygiene. Nevertheless, something apparently went amiss. Perhaps it was because academic psychology (and with it, education) rejected Hall and James and the humanistic point of view and became engrossed in measurements and physiology instead. Perhaps Freudian concepts were too abruptly and too uncritically introduced into mental hygiene work. However that may be, much of what these men stood for has only recently been rediscovered by educators and other workers in the field of human relations.

We are chiefly concerned here, however, with developments in psychiatry rather than in the public's awareness and interest, and, in that area, two questions in regard to Meyer remain to be answered: how he expanded these early convictions about the value of the life history into a body of theory, and what ramifications his ideas and teaching have had for child psychiatry.

The basis of Meyer's approach to the problems of psychiatry is his Huxleyan conception of science as "organized com-

mon sense."¹⁴ The scientific method, he says, demands "first, exact observation and experimental control of facts, and second, methodical formulation of the facts and the principles or laws."¹⁵ This method,¹⁶ which originally aimed at discovering uniformities among series of events or cases, is applied by Meyer to the individual case as well, so that the study of each patient becomes in one sense an exercise in psychiatric research. Actually, of course, Meyer's observations of patients and study of their life histories proceed from a set of assumptions as to which classes of data are relevant to the problem. The dominating conception here is that "mind . . . is a sufficiently organized living being in action; and not a peculiar form of mind-stuff."¹⁷ With this formulation he discards psycho-physical parallelism and lays the basis for his psychobiology. Describing his concept in more detail, he writes:

Mental activity is really best understood in its full meaning as the adaptation and adjustment of the individual as a whole, in contrast to the simple activity of single organisms such as those of circulation, respiration, digestion, elimination or simple reflex activity. . . . The concrete conduct and behavior . . . is the main thing deranged in our patients. . . . The mental facts we speak of are not mere thoughts but actual attitudes, affects, volitions, and activities, and possibly disorders of discrimination. . . . If mental factors meant nothing, psychotherapy would be a snare and a delusion.

¹⁴ Adolf Meyer, "Scope and Teaching of Psychobiology," *Journal of the Association of American Medical Colleges*, Vol. X (1935), p. 93-98.

¹⁵ Adolf Meyer, "Growth of Scientific Understanding of Mentality and Its Relationship to Social Work," *Proceedings of the National Conference of Social Work*, 1923, p. 193.

¹⁶ Opponents of the method protest that "without an anticipatory idea or hypothesis we do not know what specific facts to look for and cannot recognize what is relevant to the inquiry," and that it is "not easy to start with observing the facts, for to determine what are the facts is the very object of scientific inquiry." Morris Cohen, "Scientific Method," *Encyclopaedia of the Social Sciences*, Vol. X, p. 391.

¹⁷ Adolf Meyer, "The Role of the Mental Factors in Psychiatry," *American Journal of Insanity*, Vol. LXV (1908), p. 43-45.

And, in another connection, he comments:

We study behavior not merely as a function of the mind and of various parts of the body, but as a function of the individual, and by that we mean the living organism, not a mysteriously split entity.¹⁸

Accordingly, Meyer's search for mental factors consists of a "frank and reasonably balanced review of man's responsiveness and his positive and negative assets in the form of specific samples from the whole wide range of practical performance." Jobs, interests, ambitions, the "balance of performance and ambitions and opportunities," and the capacities for satisfaction and for "constructive composure"¹⁹ are reviewed, as well as hereditary and physical factors, giving a "science which accepts man as a product of physico-chemical, biological and psychobiological integration, an intrinsically social type of individual, the heir, structurally and culturally, of a succession of civilizations."²⁰

Meyer does not deny, of course, that certain mental conditions are due to the disorders of particular organs. Such causes he classifies as "non-mental" and considers the "mental facts" in such diseases as incidental to the main problem. But, by and large, he finds the apparent disorder of organs incidental in a development involving the reaction of the individual as a whole.²¹ To him the functioning individual is the important fact, and he seems to dislike generalizations and hypotheses that obscure the particularity of the individual case. Accordingly, Meyer has no logically derived system of causes by reference to which mental disorders may be explained. He

¹⁸ Adolf Meyer, "Scope and Teaching of Psychobiology," *op. cit.* (n. 14), p. 93.

¹⁹ Adolf Meyer, "Growth of Scientific Understanding of Mentality and Its Relationship to Social Work," *op. cit.*, p. 196. "Constructive composure" is here defined as "putting oneself together in rest for new activity and new responsiveness."

²⁰ *Ibid.*

²¹ Adolf Meyer, "The Role of the Mental Factors in Psychiatry," *op. cit.* (n. 17), p. 47.

describes them broadly as "peculiar mental tangles,"²² attributable frequently to constitutional defects, temperamental imbalances, and personality deviations. Hereditary and other physical factors, environmental influences, faulty habit training play their parts in the production of the unsatisfactory mental condition, but the specific dynamics of the process he nowhere describes. This point of view would seem to have both assets and liabilities. It keeps the attention of the therapist fixed upon the patient and his feelings and experiences instead of leading him to search for hypothetical mechanisms. But, on the other hand, it furnishes few bases from which a theory of therapy can proceed. This latitude in approach may account for the fact that there is so much divergence in the therapeutic practices of psychiatrists who were trained by Meyer. Freudian, Rankian, Adlerian theories can apparently be easily grafted to an original Meyerian stock, or the therapist may continue in any direction that he designates as common sense.

Meyer's own analytic and therapeutic procedures seem to be rather matter-of-fact derivatives of his general position. Psychotherapy he views as the "regulation of action." "This is why," he says, "we teach patients to actually take different attitudes to things. Habit training is the backbone of psychotherapy; suggestion merely a step to the end and of use only to the one who knows that the end can and must be attained. . . . Much psychopathology and psychotherapy will depend on the bracing of weak organs; but its work is not concluded before the patient is shown the level of his mental metabolism, the level of efficient anabolism and catabolism in terms of conduct and behavior and efficient meeting of the difficulties worth meeting and avoidance of what otherwise would be a foolish attempt."²³ To this end, the patient's assets and

²² *Ibid.*, p. 42.

²³ Adolf Meyer, "The Role of the Mental Factors in Psychiatry," *op. cit.* (n. 17), p. 46-47.

adaptive tendencies or difficulties are determined and are reduced to "non-mental or mental factors." Then the "conflicts, inhibitions, or one-sided fixation of reactions" are adjusted by "re-education and by the use of capacities unnecessarily checked, by immunisation to morbidly sensitive complexes through a better understanding or through suggestion."²⁴ Attention is also given to straightening out the environmental situation, easing the strains imposed by the patient's family or other situations that may be too much for him to cope with.²⁵ These methods Meyer views as containing the essential elements of most modern approaches, which he sees as being comparable to the use of "auto-vaccines—learning to see and accept oneself in one's past and present tendencies . . . and a realignment of the assets and adaptation of both ambition and attainable situations with habit-training."²⁶

MEYER'S INFLUENCE ON THE DEVELOPMENT OF PSYCHIATRIC CLINICS FOR CHILDREN

While many of these principles are basic to child psychiatry as generally practiced in the United States, Meyer had an even more direct influence upon the development of state-supported psychiatric services for children. In his writings between 1895 and 1909, one can find specifically stated many of the ideas that now guide the work. Broadly considered, they are the interrelated concepts of prevention, psychiatric social service, and the mental hospital as the center of mental health work. The origin of all these ideas is clearly traceable to Meyer's insistence upon obtaining more knowledge about the lives of patients. He tells that this was the reason for his initiating extramural work in the Pathological Institute

²⁴ Adolf Meyer, "The Scope of Psychopathology," *Psychiatric Bulletin*, July 1916, p. 302.

²⁵ Adolf Meyer, "The Role of the Mental Factors in Psychiatry," *op. cit.* (n. 17), p. 48.

²⁶ Adolf Meyer, "The Scope of Psychopathology," *op. cit.* (n. 24), p. 304.

(Ward's Island, New York).²⁷ His wife acted as the home visitor and is therefore credited with being the first psychiatric social worker. To this work of collecting additional information about patients was soon added that of helping to prepare the home for the patient's return. Meyer's interest in "after-care" services dated from about 1898, when he collected material on that subject from Switzerland and England. At Ward's Island he succeeded in diverting a charity-oriented proposal of the State Charities Aid Association to what he considered the more important work of obtaining facts and counseling with families in regard to the patients' care. While providing money and helping with employment might be important in some cases, he believed that "those families that are poor in experience and poor in mind are most in need of help."²⁸

From providing psychiatric social workers to help with the patients' post-hospital adjustment, it was a short step to setting up clinics in which potential patients might find aid. The use of prophylactic measures against mental disorders was a logical corollary of Meyer's point of view with regard to the causes of those conditions. Discussing after-care work in 1909, he noted what was apparently his long-held conviction that "mental disease is much more easily prevented than cured."²⁹ In the same year he wrote:

Not only must the State or the public provide for the best possible medical treatment and for the physical welfare and comfort of its huge number of patients, but it must strive to make its institutions centers of progress, which must be concerned not only with meeting the emergencies of the day but with the more far-

²⁷ Adolf Meyer, "The Extra-institutional Responsibilities of State Hospitals for Mental Diseases," *Proceedings of the Meeting of the Joint Board of Trustees of the State Hospitals of Michigan held at the Kalamazoo State Hospital*, July 20, 1916, p. 6.

²⁸ Adolf Meyer, "The Extra-institutional Responsibilities of State Hospitals for Mental Diseases," *op. cit.* (n. 27), p. 7.

²⁹ Adolf Meyer, "After-care and Prophylaxis," *State Hospitals Bulletin*, March 1909, p. 3.

reaching problems of prophylaxis and of stemming the tide of increase. The institutions for the insane must indeed become the nucleus of a far-reaching work for social and individual mental hygiene and mental readjustment.³⁰

He envisaged a plan by which the state hospitals would bring their unique experience within the reach of the physicians and the public of their districts.³¹ His proposal was to divide states into hospital districts in which state and local interests could be combined. Hospital psychiatrists would engage in the extramural work of parole and prevention and collaborate with local physicians, who would use the hospital as a consulting center. To promote this latter end, it would be necessary for state hospitals to set up active treatment services for in-patients and so equip the staff psychiatrists for consultation work.³²

In addition to being of value to the communities, it was held that extramural services would be useful to the state hospitals themselves, in that by this means the training of the ward psychiatrists would be broadened. By working in extramural clinics they would get a "much better sense for the individual characteristics of the cases" and the hospital would accordingly be "rid for good of that serious blight . . . that tendency to consider the principal task in psychiatric work to say whether a case is manic-depressive or one of dementia praecox, a frequently peremptory pronouncement which too often means hope or doom, interest in the case or surrender. By seeing more of the cases and their causes in the developmental stages, a new world of interesting problems looms up. One learns to train one's eye to see many human and psychi-

³⁰ Adolf Meyer, "The Problem of the State in the Care of the Insane," *American Journal of Insanity*, Vol. LXV (1909), p. 690.

³¹ Adolf Meyer, "The Problem of the State in the Care of the Insane," op. cit., p. 690.

³² Adolf Meyer, "The Extra-institutional Responsibilities of State Hospitals for Mental Diseases," op. cit. (n. 27), p. 12.

atrical features far more important than these ultimate classifications.³³

As to work with children, that too was a logical development of Meyer's point of view. As early as 1895 he contributed several articles about the mental abnormalities of children to the Society for Child Study,³⁴ which was sponsored by G. Stanley Hall. Later his work with psychotic patients led him to an interest in their childhood problems.

In harmony with my dynamic conceptions of most mental disorders, I had to reach out, in my actual work, more and more toward a broader understanding of the patients, which led me to a study of the family settings, and by and by [about 1903], also of the place where the individual first becomes a member of the community, the school.³⁵

From these studies Meyer came to the conclusion that "knowledge of the mode of development of some of the graver mental disorders must help us to discriminate those traits of character that should serve as warnings to be heeded," although he noted also (what others have at times overlooked) that traits like seclusiveness, day-dreaming, and discrepancies between thought and action are not sufficient indications of inevitable failure.³⁶ He urged the schools to adapt their methods and curricula to the needs of all children, not only the brightest, and to put more emphasis on doing and less on knowing, while for the extremely maladjusted children he proposed the establishment of "hospital schools."³⁷ Nor did he

³³ Ibid., p. 13.

³⁴ See *Transactions of the Illinois Society for Child Study*, 1895; the *Handbook* of the same society for the same year; and *Child Study Monthly*, Vol. I, 1895.

³⁵ Adolf Meyer, "Thirty-five Years of Psychiatry in the United States and Our Present Outlook," *American Journal of Psychiatry*, Vol. VIII (1928), p. 16.

³⁶ Adolf Meyer, "What Do Histories of Cases of Insanity Teach Us Concerning Preventive Mental Hygiene during the Years of School Life?," *Psychological Clinic*, Vol. II (1908), p. 95.

³⁷ Ibid., p. 98-101.

view work with children wholly in terms of preventing future mental disorders, some of which his theories led him to conclude were almost unavoidable at best. He emphasized instead the need for giving help to all who suffered, regardless of future contingencies, saying:

To those who think that it is scarcely worth while to trouble ourselves about the few who would fall by the wayside anyhow, I can address no stronger plea than to urge that what often leads to complete breakdown in some will partly spoil the lives of others or at least seriously interfere with their success.³⁸

In addition to offering help to problem children through hospital clinics, Meyer early proposed that child psychiatrists be placed in schools to cooperate with the teachers in helping "the child and parents find the best level and direction of ambition adapted to the individual endowment."³⁹ From there, his conception of the applicability of psychiatry broadened to take in even wider aspects of human life, so that in 1913 at the opening of the Phipps Psychiatric Clinic he could say:

Psychiatry . . . will have to furnish many facts for the experience on which we can build the elements of real culture. As soon as psychiatry enters upon the disorders below the arbitrary level of declared insanity; as soon as it pays attention to what has quite unnecessarily been left to untrained teachers; as soon as we become helpful in schools, in teaching how to shape mental life effectively, how to make the most of an individual's endowment instead of destroying much by attempting the impossible; as soon as we make our field a matter of obligatory study to the psychologist and create outlooks on the cultural benefits of psychiatry, the world will find psychiatry less like an initiation into a dark corner of human life, but more and more a broadener of common sense.⁴⁰

³⁸ Ibid., p. 97.

³⁹ Cited by Esther Loring Richards, "Some Adaptive Difficulties Found in School Children," *Mental Hygiene*, Vol. IV (1920), p. 332.

⁴⁰ Adolf Meyer, "Closing Remarks," *American Journal of Insanity*, Vol. LXIX (1913), p. 1085.

FREUDIAN CONCEPTS IN AMERICAN CHILD PSYCHIATRY⁴¹

Although Meyer's proposals concerning the use of state hospitals for preventive work were made in the early years of the century, the idea took hold slowly, and few clinics for children were set up under such auspices before 1920. In the meantime, the mental hygiene movement had become a thriving institution, and Freudian theories had been added to Meyerian to support the interest in child psychiatry.

The contributions of Freudian theory to American child psychiatry were more specific—though perhaps less widely accepted—than those of Meyer. Meyer's chief contribution seems to have been his point of view; his insistence upon the wholeness of human behavior and upon the uniqueness of each individual case. To those concepts students of Freudian theory added more specific theories that were thought to account for many of the difficulties that they observed in their child patients. On the one hand, Freud's teachings reinforced a viewpoint already made more or less familiar by the work of G. Stanley Hall and William James. Personality, according to Freud, is the result of a genetic process in which emotions play a dominant role and environmental influences frequently outweigh those of heredity. With this the "common-sense" psychiatrists could agree. As Meyer⁴² once wrote, psychoanalysis to him was an attempt to "see man . . . in really human, vital terms—that was to my mind the fundamental contribution and stroke of genius of the movement." He continued:

Back of the supposedly banal realities of ordinary human experience Freud had the courage to see a latent unconscious reality in the form of mankind's struggle for happiness reflecting itself in the individual life; and especially in the naive dream more personally expressed than in socialized waking life. . . . Freud's

⁴¹ For further discussion of this topic see Chapter XII.

⁴² Adolf Meyer, "Growth of Scientific Understanding of Mentality and Its Relationship to Social Work," *op. cit.* (n. 15), p. 195.

theory has proved most fruitful, fascinating, and stimulating where plain common sense could not make an impression. It has the vital elements that were lacking in most other efforts: it is intensely dynamic and speaks of absolute determination of life in contrast to the peculiarly timid evasion of casual thinking in most psychologies.

Freud, however, made the genetic concept more specific and more dynamic by showing exactly how environmental influences facilitate or hinder the instinctual processes of sex and aggression. In so doing he ran the risk of setting up prototypes to which all the complexities of human behavior could be reduced and hence of obscuring again the individuality of the particular case. This, it seems, is one of Meyer's chief objections to Freud's theory. In skilled hands, however, the Freudian analysis escapes that danger by the recognition of the devious and particularized ways in which the postulated instincts find expression.

To child psychiatry the special importance of the instinct theory lies in the demonstration of the reason for the importance of parent-child relationships and in the new basis the theory gives for the conviction that the individual is capable of self-direction. In regard to the first, the Freudian theory holds that the parents supply the initial situations of security and frustration through which the infant's instinctive desires develop into an ability to comprehend reality and to incorporate its commands. It is postulated that the child reacts to the first, inevitable deprivations by phantasies arising out of the thus-stimulated death instinct. If subsequent reality—in the form of the parents' attitudes toward him—does not dispel these hostile phantasies, his later reactions are likely to be colored by fear, aggression, and excessive irrationality. On the other hand, overattention and solicitude on the part of the parents may be as damaging as lack of affection, since these attitudes tend to keep the child from developing certain

mechanisms necessary in meeting later life difficulties. As to self-direction, Freud's theories of instinct development again imply that the prime forces lie within the child himself. Parental attitudes and cultural conditions are the environment in which and toward which the child acts, but the use he makes of them derives from himself alone.

Another concept described by earlier psychologists but elaborated upon by Freud is that of the purposiveness of behavior. The apparent contradictions to this principle that are exhibited by the bizarre activities of psychotic individuals and the caprices of problem children disappear when it is recognized that many mental processes are unconscious and that motives have devious ways of expressing themselves in behavior. These principles lead the child psychiatrist to seek for the meaning of his patients' behavior symptoms and to find them sometimes in the irrational and unconscious areas of mental life. Finally, Freudian theory adds to child psychiatry some methods of therapy. It demonstrates the importance of transference phenomena, and it casts doubt upon appeal to reason as the chief therapeutic instrument.

Since it is one of the main principles of Freudian theory that the bases of many neuroses and psychoses are laid down in early childhood, it was a natural deduction of clinical workers that prevention should begin early. As has been shown above, this principle is one with which Meyer heartily agreed, so a program of preventive work appealed to psychiatrists of both schools of thought. William A. White⁴⁸ in 1917 described mental hygiene as "the last word in preventive medicine," and a few years later he wrote:

If it is true that defects in the character make-up can be explained as originating in traits which were acquired in early

⁴⁸ William A. White, "Underlying Concepts in Mental Hygiene," *Mental Hygiene*, Vol. I (1917), p. 14.

childhood as reactions to certain factors in the child's environment, then the way is opened for an attempt to prevent such undesirable traits by an understanding of the child and a modification or elimination of those environmental factors which produce such results.⁴⁴

Under the influence of White,⁴⁵ Salmon, and others, the National Committee for Mental Hygiene began, about 1920, to turn from adult psychiatry to child guidance, and a program demonstrating child guidance work was entered upon in 1922. Thus, by about the time that Meyer's teachings were becoming effective in some state hospitals, and clinic services for children as well as adults were being considered there, the somewhat more Freudian-oriented child guidance clinics were being established under private auspices in a group of large cities.

The details of these parallel movements will be described in a later chapter. Here it is to be noted, in summary, that the chain of development that began in America with Meyer's insistence on studying the total individual rather than the functioning of specific organs led logically to the situation that was described at the opening of this chapter—the presence of all types of problem children in psychiatric clinics. By the same process the mental hygiene movement was saved from being a mere repetition of the Dorothea Dix crusade. Meyer's hypothesis that mental activity represents the adaptation and adjustment of the individual as a whole provided a basis on which the various schools of dynamic psychiatry could unite. By it distinctions between normal and abnormal were abolished, and the whole range of human behavior became of interest to the psychiatrist. The history of the mental

⁴⁴ William A. White, "Childhood, the Golden Period for Mental Hygiene," *Mental Hygiene*, Vol. IV (1920), p. 261.

⁴⁵ Adolf Meyer, "Organization of Community Facilities for Prevention, Care, and Treatment of Nervous and Mental Diseases," *Proceedings of the First International Congress on Mental Hygiene*, op. cit. (n. 12), p. 247.

hygiene movement is an unfolding of the possibilities inherent in that concept. Better care for the psychotic individual, prevention of psychoses, prevention of other forms of social and psychic maladjustment led eventually to the conviction that these were unsatisfactory goals, and mental hygiene became a "positive program for life well lived, for mental health because of its values and not because of what it avoids."⁴⁶

⁴⁶ William A. White, "The Origin, Growth, and Significance of the Mental Hygiene Movement," *Proceedings of the First International Congress on Mental Hygiene*, op. cit. (n. 12), p. 533.

CHAPTER TWO

The Basis of Clinical Child Psychiatry: Social Attitudes and Institutions

MENTAL hygiene requires something more than a body of theory and a group of practitioners. It requires, in addition, an informed and sympathetic public that will provide the supporting values and institutions and, in part, will participate in the work. In this it is like other social movements. Political dictators, campaigners in the interests of public health or new morals, all who would change the public's attitudes and ways of life must first build up some support before they can make their regulations effective. But mental hygiene differs from these others, since, working as it does solely with feelings and attitudes, it cannot at any stage of its development use authoritative methods. People cannot be forced to be tolerant of one another's idiosyncrasies. Even when there is a body of public opinion which is sympathetic to the mental hygiene point of view and attempts to enforce its prescriptions through social pressure, many of the individuals who most offend in their relations with other people can hide their offenses not only from society but from themselves.

There are two elements in the attitudes of people toward human relationships. One reflects their personal, emotional adjustment; the other, the culture in which they have been reared. About the first a program of mental hygiene education can probably do little. There will always be individuals whose impulses toward other human beings are sadistic or who are so engrossed in their own feelings that they cannot respond sympathetically to others. They cannot be altered by

new ideas, for the basis of their attitudes is not in the intellectual sphere. But there are other people whose standards of conduct for themselves and others reflect more directly the values and traditions of the society in which they grew up. Such standards cannot be easily brushed aside and superseded by others antipathetic to them, since they too have become part of the personality of the individuals who live by them. Nevertheless, there is a flexibility in culturally derived modes of thought and action that is relatively lacking in those that represent other aspects of emotional life. If it were not so, culture itself would be static, and education would consist solely in transmitting the old forms of thought. To enlist for a child psychiatry program the cooperation of a community that is ignorant of mental hygiene means, therefore, working with that part of its attitudes toward people that are based on its culture. It is an educational, not a therapeutic, task.

Such an educational endeavor starts with certain attitudes of the public in its favor. There is, in the first place, a widespread interest in the child. This is particularly characteristic of the present century, and child psychiatry itself is one of its symptoms. The exact origins of that interest are difficult to trace, but the part played by the psychologists who took part in reforming nineteenth-century psychiatry has already been noted. Recent years have seen a great extension of interest and concern with the problems of childhood and youth. Child health programs flourish, and pediatrics is a widely accepted special field of medicine. Educators, starting with a reform of kindergarten methods, have carried progressive education up and into the colleges. Criminologists, first concerned with the plight of the very young offenders, now talk of using the methods of the juvenile court and of the reform school with adult criminals. Protests against child labor grow into an interest in bettering all working conditions. In fact, in contrast

to the developments in psychiatry, most recent movements for human betterment seem to have started with the child and worked upward toward the adult.

In entering a new community, then, a child psychiatry program would seem to be assured of an initially favorable reaction because it offers help in an area in which there is much public interest. But that does not always prove to be the case. The reason is perhaps to be found in the fact that psychiatry is inclined to deal with matters in regard to which there has not been as much change in attitude as the widespread interest in child welfare would imply. The reforms in physical care of children and in their education, and those concerned with child labor do not involve the radical changes in concepts about human nature that are required by certain theories of psychiatry.

What, then, are some of the dominant ideas and values in American life that are incompatible with a child psychiatry which is conceived as something other than treatment of organic illness? To answer that adequately is much beyond the scope of this book, but a few of the most prominent ideas need to be noted so that some of the difficulties that child guidance clinics encounter can be understood.

SOME AMERICAN ATTITUDES RELEVANT TO A PSYCHIATRIC PROGRAM

Most persistent among American beliefs that may handicap psychiatric work is the faith in the guiding power of reason and the conviction that social conformity is a matter of conscious control. The educated person of the present day may take the psychological concept of the undifferentiated nature of the new-born child more or less for granted, yet there still remains in our culture a considerable heritage from theology that has bearing upon this question. Although it may be that few people subscribe to the bald statement that

a child is born with an innate endowment of original sin and a will to carry it out, still it is widely held that certain children are naughty more or less from birth, and that the will to be good or bad is not only early manifested but is deliberately invoked. The role of the parent in the process of personality growth is far from adequately understood, and parents are commonly considered blessed or to be pitied, depending upon what sort of children God or fortune has given them.

By the educated or tolerant, these would doubtless be considered overstatements, and there are, to be sure, certain counterbalancing notions among our guiding ideas. The spoiled child's conduct, for instance, is to some extent attributed to his parents, and the neglected or overdominated child is not held fully to blame for his actions. Nevertheless, even among the enlightened there is little appreciation of the influence of emotions as determinants of behavior. Some people are considered foolish, shallow, overemotional, or too rigid; others are said to behave in accordance with common sense. But why they act as they do, few inquire; and, if explanations are given, the causes are usually found in some weakness or strength of moral and intellectual fiber.

If common beliefs still make the child largely responsible for his behavior, how much more generally is it held that delinquents and criminals are to be blamed for their misconduct? Here, to the average mind, are adolescents and adults who deliberately engage in acts that they know are wrong or who are so weak that they engage in misconduct because of the pressure of circumstance or the example of bad companions. It is clear that they should be punished—in part for the sake of their own reformation, in part that others should be deterred from following their example. On the other hand, there is not universal agreement as to what is delinquent behavior. Acts which at one end of the economic scale bring a boy before the juvenile court are apt at the other extreme to be condoned as

evidence of youthful high spirits, while among adults the old distinction between the propriety of stealing food and stealing a railroad still holds. As a recent investigator points out, "group attitudes and group customs enter definitely into the concept of delinquency; whether or not a child's behavior will be considered social or antisocial is partially dependent upon them."¹

As to the insane and the feeble-minded (they are apt to be grouped together), the shiver with which the thought of them is greeted bears witness to the power of the earlier idea that they are, in some way or other, people "possessed." We fear them, and we consider them a class apart. Abnormality has a definite meaning to the lay mind. Holding fast to his faith in rationality, the average citizen dismisses as abnormal any conduct that he cannot account for in terms of common sense or deliberate perversity, and in the abnormal he sees no reflection of himself.

Mental disease—in the words of a psychiatric commentator²—is considered "burdensome, annoying, suspicious, even sinister." It is widely held to be due to a "strange and unalterable fate," a punishment for early sins or an evidence of hereditary taint. The patient is in many ways an outcast, and his family is more or less disgraced. These feelings of the majority of the public about mental disease often find confirmation in the way mental hospitals are administered. Regarding this aspect of the matter, Meyer³ has written:

¹ Sophia Robison, *Can Delinquency Be Measured?*, New York, Columbia University Press, 1936, p. 205.

² Hans Roemer, "To What Extent Does Public Opinion Help and to What Extent Does It Impair the Work of Mental Hygiene?", *Proceedings of the First International Congress on Mental Hygiene*, op. cit., p. 267-70. See also Charlotte Adland, "The Attitudes of Eastern European Jews toward Mental Disease: a Cultural Interpretation," *Smith College Studies in Social Work*, Vol. VIII (1937), p. 85-116.

³ Adolf Meyer, "The Aims of a Psychiatric Clinic," in F. E. Hodgens, *Report on the Care and Control of the Mentally Defective and Feeble-minded in Ontario, 1919*, Appendix S, p. 226.

Our organized system for the care of mental disorder is in many respects forbidding. It throws together all kinds of diseases and shocks in that way the already sensitive patient (and, one might add, his relatives) who fears the worst for himself or herself. It comes at once with an outspoken declaration of insanity in the very commitment to a hospital, an expression which carries a humiliation to the patient and adds insult to injury. It often means carrying the patient off to a remote asylum which is too widely supposed to have the inscription, "Leave hope behind all ye that enter here."

As a corollary of such attitudes, the man on the street tends to fear the psychiatrist and hold him in disrepute. This attitude persists even after there has been some public acceptance of mental disorders as illnesses for which the patients are not to blame. Psychiatrists are generally considered—even by their medical colleagues—narrow, one-sided, unacquainted with the world, too inclined to see mental abnormalities where they do not exist, and, on the other hand, to take too lightly the question of retaining patients in hospitals.⁴ The injunction "Physician, cure thyself!" is frequently thrown at them, and there is a widespread feeling that only a person who himself leads a model life, has radiant, socially conforming children, and himself exhibits perfect emotional adjustment is capable of helping others with their personal problems.

To go to a psychiatrist for help is widely considered an admission of failure. One might seek the assistance of a psychologist (though that profession also connotes mental abnormality), or, more easily, the advice of a person who sets himself up as a professional counselor. Counseling implies to the average man assistance on the intellectual level. He would prefer to make his decisions wholly alone, but he can admit that he occasionally needs an outsider's objective point of view. Help in making a decision (often a decision about what to do about somebody else) is a very different matter,

⁴ Hans Roemer, *op. cit.*

however, from admitting that there is "something wrong with your mind," and the latter is what a visit to a psychiatrist means to most people.

Much the same feelings may enter into taking a child to a psychiatric clinic. The parent admits to himself and—perhaps more painfully—to the world that he has been a failure. There will be much gossip about the matter, he knows, if it is ever discovered. He may use the clinic to punish the child or to justify his own feelings about the child's unworthiness, or he may genuinely be wanting help. These are individualized reactions, with complicated motivations. But the cultural fact is that in most American communities most people, regardless of their attitudes toward their children, regard psychiatric clinics as a place of last resort because, under whatever auspices they are conducted, they connote mental abnormality and failure of that control by reason which is so highly prized.⁵

It is with attitudes such as these that mental hygiene and child psychiatry must work. Psychiatrists sometimes attribute these attitudes to a kind of group guilt. We thrust aside the insane and the criminal, the offensive schoolboy and the street ragamuffin because we cannot endure the pain their sight invokes. We feel that but for the grace of God there go we, and we are not quite certain, in these later days, whether it is God's grace or our duplicity that has saved us from such a fate. If such is the real basis of these group mores—if they are not attributable to ignorance or are not part of a functional whole, as the sociologists would have it—it would seem that community education, the foundation stone of the mental hygiene movement, would be of little avail. Perhaps the truth lies between the two positions, and the error in the imputation of guilt feelings to a collective being called the com-

⁵ For a description of the European attitude, which has much in common with the American, see F. S. Meijers' discussion of Hans Roemer's paper, *op. cit.*, p. 286-88.

munity. History shows clearly that attitudes and behavior toward delinquents and psychotics have changed. Further education will doubtless modify the actions of those individuals in the community who are susceptible of change, while the guilt of others may be driven further underground, so that they too may acquiesce in the modification of social institutions even if their own punishing attitudes persist in other forms.

WHY THE COMMUNITY'S SUPPORT IS NEEDED

There are various reasons why the cooperation and participation of the community are so necessary a part of clinical child psychiatry. In the first place, a community, like an individual, must be aware of and concerned about its problems before it can be helped. There are doubtless individuals in any community so hard-pressed by their problems that they would utilize the services of a clinic if one were available and they knew of its purpose, just as they have utilized the services of ministers, physicians, lawyers, and ordinary citizens with a reputation for sympathy and understanding. But in many places such voluntary seeking for help would be viewed as a confession of failure, not only by the community but by the individual himself. Others, equally needy, would be ignorant of a clinic's function, and others, particularly children, would not be in a position to initiate contact with a clinic. A program of child psychiatry needs, then, a broad base of community understanding and appreciation so that those who want its services can have support in seeking help (just as they now have the backing of custom when they seek medical aid) and so that those who need its services can be recognized and offered assistance.

In the second place, clinic treatment of children presupposes the cooperation of the community because, for the most part, it does not consist of pink pills of advice nor does it rely

wholly upon direct psychotherapy. Much of treatment is carried on by persons outside the clinic staff. Teachers, ministers, police, recreation leaders, nurses, social workers in other agencies, almost anybody in the community may become an agent in treatment. Their relationship with the patient in question may not, probably should not, be that of a professional therapist, but their conscious participation in a treatment program is frequently necessary and will be worse than useless unless they, through knowledge or intuition, are in sympathy with the assumptions of mental hygiene.

Even more than this direct assistance with its treatment program, a mental hygiene clinic needs cooperation in the form of social institutions and attitudes that foster healthy mental growth. It is much more important, for instance, that the school program be oriented toward the development of all children's varied capacities than that teachers be able to recognize problem children and modify the program to fit their needs. A recreational program adapted to the needs of children in general is of more value than the presence of some recreational leaders who act as friends to the maladjusted. A public opinion that will not permit slums and gangster activities and low standards of wages and living will not only provide conditions that facilitate mental hygiene treatment but will aid in the fostering and maintenance of mental health.

The fulfillment of such conditions, as the community's contribution to mental hygiene, may be far in the future. A more immediate necessity forcing the securing of cooperation from the community before a child psychiatry program can be initiated and maintained is the need for financial support. Staunch individualists may hold that mental health services should be private and self-supporting, that patients should pay for mental therapy as they do for physical treatment, but two conditions work against that conclusion. In the first place, mental health services, such as child guidance clinics offer,

are too expensive to be paid for by any except the wealthy. More important, child guidance treatment as customarily carried on is more than individual treatment. Working as the clinics do with courts, schools, and social agencies, with professional individuals of various types and with the patients' friends and relatives, child guidance becomes an education in a point of view for numerous people and, hopefully, benefits many more than the individual patient. At the same time, to carry on treatment in this manner requires that the clinic have a community backing that is symbolized by financial support, so that it functions as an agency of the community rather than as a professional consultant of the individual patient.

If this is so, the financial support of mental hygiene clinics must be assumed either by local communities, through private subscription or public funds, or by larger governmental units, or by the two combined. Private funds have been the chief source of support of clinics in large cities, though some such clinics (notably those in schools and courts) are financed by taxes. It has been found that a clinic composed of a psychiatrist, psychologist, and two or three social workers can serve three to four hundred patients a year and that it costs in salaries about \$20,000.⁶ So far no communities with less than 150,000 population have supported such a full-time clinic out of their own resources. There are, however, various precedents for the assumption by the state of at least partial responsibility for a problem that has the wide social implications of mental hygiene, the two services most nearly resembling it being public health and public education.

WHAT THE PUBLIC GAINS FROM PSYCHIATRIC SERVICE

The more specific reasons why the state should undertake at least part of the costs and direction of mental health serv-

⁶ George S. Stevenson and Geddes Smith, *Child Guidance Clinics: A Quarter Century of Development*, New York, The Commonwealth Fund, 1934, p. 55.

ices are clear from what has already been said about mental hygiene. The alternative costs in the damage done to society by criminals and psychopathic individuals and in their care if they become institutionalized is the usual answer to the question. It has been suggested also that there are values in fostering the mental health of all citizens that far outweigh those that might accrue to a community if crime and mental disease rates were reduced. In addition, it might be pointed out that each one of the thousands that enter court or hospital represents numerous others who have been handicapped by his deeds or misfortune. There is probably little of heredity in crime or mental disease, but their social accompaniments are as disastrous as any inheritance through the germ plasm. Maladjustment breeds maladjustment, socially if not biologically, and the actual number of delinquents, criminals, and mentally ill represents only a fraction of the loss to society.

There is an infectious element in mental ill health. Children are probably more handicapped by emotionally maladjusted parents than they are by unsanitary living conditions. And problem children, so the mental hygiene teaching runs, are very apt to become the problem parents of the next generation. This cycle of poor mental health must be broken if progress is to be made. Child guidance is mental hygiene's suggestion of a way out, though it recognizes that this is no panacea eliminating the need for other modes of attack on the problem and no magical device by which all, willy-nilly, can be cured. Such a plan necessitates, however, a broadening of the reason for the state's undertaking mental hygiene measures. Now the objective is no longer only the prevention of delinquency and mental disease, and the patients are no longer only the extremely maladjusted. Child guidance takes as its patients any children who in behavior or personality traits seem to deviate in a way that is suggestive of inability to cope with the requirements of social life. It hopes, through

offering them help in working through their conflicts or in adjusting the environment to fit their needs, to salvage them both for their own sake and for the sake of the next generation, even though there is little likelihood that they will become either criminal or psychotic.

Such a conception of state function and responsibility—one that envisages giving services in the interest of the individual himself (that he may enjoy the full use of his potential capacities) and not chiefly in order that he shall do no harm to the group—is one that is only partly in line with modern tradition. Whitehead,⁷ tracing the adventurous course of ideas across the centuries, shows that belief in the “essential rights of human beings arising out of their sheer humanity” started as a speculative suggestion in the mind of Plato, was made specific by early Christianity, and was carried into action by the sceptical humanitarianism of the eighteenth century through the agency of the French Revolution. Against it the dominant new ideas of the nineteenth century were arraigned: the economic doctrine of unrestrained competition, the Malthusian principle, which was interpreted to mean that nature’s law decreed that the majority of mankind could never attain a state of well-being, and the Darwinian conclusion that progress was achieved only by means of the elimination of the weak. With these ideas were allied the Puritan conception of individualism, itself a reaction to the feudalism which it supplanted. As Tawney says:

The moral self-sufficiency of the Puritan nerved his will but it corroded his sense of social solidarity. . . . Convinced that character is all and circumstance nothing, he saw in the poverty of those who fell by the way, not a misfortune to be pitied and relieved, but a moral failing to be condemned.⁸

⁷ Alfred North Whitehead, *Adventures of Ideas*, New York, The Macmillan Co., 1933, Chapters I and II.

⁸ R. H. Tawney, *Religion and the Rise of Capitalism*, London, John Murray, 1926, p. 231.

In present-day America these two sets of ideas are still in conflict, most dramatically in politics, less obviously in mental hygiene. To individualists mental hygiene is "sold" as a kind of insurance, with low premium rates, against the costs of crime and insanity. To humanitarians it seems a service that the government should offer to all who desire it, an aid to that full enjoyment of potentialities which they see as the right of every human being. State mental hygiene clinic staffs doubtless themselves vary in their opinions on this subject. Even if they did not, they could not go far beyond the attitudes of the people in the communities which they serve. For the effective conduct of child guidance presupposes a unity of purpose in client, clinic, and community. Such a unity can never be completely achieved but it is the animating goal of the mental hygiene movement.

CHAPTER THREE

Evolution of Psychiatric Clinics for Children

TO trace out in detail the lineage of the present psychiatric services for children is the task of a future historian, but it may add to our understanding of some of the current disputed issues in the field of child psychiatry to note the main lines of development. These appear to have been three. First there is the early work of mental hospitals and schools for the feeble-minded. These can be grouped together so far as clinics for children are concerned, for, on the one hand, the hospital clinics apparently made little distinction between feeble-minded and children otherwise maladjusted, while, on the other hand, few schools for the feeble-minded had psychiatrists on their clinic staffs. The second line of development is found in clinics for juvenile delinquents, while the third (which resulted in part from a fusion of interests of the first two) is that which began with the Commonwealth Fund's program of demonstration child guidance clinics.

EARLY DEVELOPMENTS IN STATE HOSPITALS AND SCHOOLS FOR THE FEEBLEMINDED

Although extensive developments in mental health work, especially with children, came only after psychiatrists and, to some extent, the general public had developed a new point of view with respect to the nature of psychic maladjustment, the first psychiatric clinics were set up during the period of interest in mental disease as such. As Meyer so frequently pointed out, psychiatrists in the latter part of the nineteenth century were chiefly concerned with problems of neuropathology and the classification of mental diseases. Nevertheless, there was even at that time some interest in preventive work. Books and articles on the subject of mental hygiene appeared at infre-

quent intervals following the publication of a volume bearing that title by William Sweetster in 1843.¹ As early as 1871 the California State Board of Health proposed the erection of a psychopathic hospital for the treatment of incipient mental disorders because it believed that much permanent insanity was due to the lack of early care.² A few years later the short-lived National Association for the Protection of the Insane and the Prevention of Insanity was formed, whose purposes closely paralleled those of the present National Committee for Mental Hygiene.³ Then dispensaries and clinics for mental patients slowly began to appear. The earliest is said to have been established by Dr. John B. Chapin in the Pennsylvania General Hospital in 1885, followed soon after by one in the Warren (Pennsylvania) State Hospital.⁴

The Pennsylvania Hospital Clinic stated as its purpose the "treatment of mental diseases in their early or incipient stages occurring among the poor and indigent." More definitely preventive—and of greater interest here because it apparently marked the beginning of clinical work with children—was the clinic opened in 1897 under the direction of Dr. Walter Channing at the Boston Dispensary. He was particularly interested in the problem of feeble-mindedness and believed the clinic could "do much good by calling attention to these children."⁵ In this interest he may have been influenced by the work of the Massachusetts School for the Feeble-minded, for in that institution a regular day each week for the examination of outpatients was set aside in 1891, following Dr. W. E. Fernald's earlier practice of examining patients on request without formal court action. However that may

¹ Cited by Albert Deutsch, *The Mentally Ill in America*, New York, Doubleday, Doran & Co., 1937, p. 309.

² *Ibid.*, p. 291.

³ *Ibid.*, p. 310-12.

⁴ *Ibid.*, p. 296.

⁵ Quoted by E. Stanley Abbot, "Out-Patient or Dispensary Clinics for Mental Cases," *American Journal of Insanity*, LXXVII (1920), p. 219. See also article by Dr. Channing concerning this clinic, "Dispensary Treatment of Mental Diseases," in the same journal, Vol. LVIII (1901).

be, the Boston Dispensary Clinic definitely foreshadowed more modern methods of studying patients. "A mental clinic," wrote Channing in 1901, "should strive to investigate a few cases thoroughly . . . and a good deal of time should be spent on the consideration of sociological factors."⁶

More or less through the influence of Meyer other state hospitals in New York and Massachusetts began to offer clinic services. The first appears to have been the St. Lawrence (New York) State Hospital, which in 1909 opened an outpatient clinic for "poor and indigent persons suffering from incipient mental or nervous affections."⁷ The Northampton (Massachusetts) State Hospital started clinic services the next year, one of its staff physicians having himself earlier initiated the practice of visiting patients in their homes.⁸ By 1914 the Massachusetts State Board of Insanity, acting upon Meyer's suggestion that each hospital should serve as the mental health center for its district, voted that all hospitals should establish outpatient departments and conduct clinics in nearby cities.⁹ New York a year earlier had adopted a state-wide plan of the same type.¹⁰

These first clinics had several functions. Their interest in prevention through early recognition and treatment of mental disease has already been noted. More often their chief objective was to keep in touch with patients who were on parole. As a report about the New York clinics in 1912 puts it:

The parole system has not met all the expectations of those interested in its establishment, for the reason that it has been impossible to induce more than a small percentage of patients to visit the hospital in person during their parole. . . . It is thought that many more will visit the clinic than would go back to the

⁶ *Ibid.*, p. 219.

⁷ E. Stanley Abbot, *op. cit.*, p. 221.

⁸ *Northampton State Hospital Annual Report for the Year Ending November 30, 1910.*

⁹ John B. MacDonald, "The Community Value of the Out-Patient Department of the Hospital for the Insane," *Mental Hygiene*, Vol. I (1917), p. 267.

¹⁰ E. Stanley Abbot, *op. cit.*, p. 221.

hospital, because of its greater convenience, and also because many patients would be more willing to attend a medical station outside of the state hospital limits.¹¹

Finally, some of the clinics had educational objectives. The New York State Charities Aid Association commented in 1917:

These out-patient departments, bringing to the very doors of residents of communities all over the State the skilled services and competent advice of specialists, are not only having an important preventive effect, but are serving to inform the public generally about the nature, causes and treatment of mental disease, with the result that a more humane and normal attitude is coming to prevail toward the mentally sick and the institutions for their treatment.¹²

It is clear that clinics with such objectives could proceed upon a theory of psychiatry which assumed that mental disorders were wholly a matter of organic disease. Such a theory, however, would give little incentive to clinics to offer their services to any children except the mentally defective and those who were so maladjusted that they were regarded as insane. With the shift of psychiatry to an interest in total behavior and in the social and emotional genesis of mental disorders, it was a natural step for clinics to seek to aid children who were socially maladjusted. Meyer had early talked and written of the possibility of doing preventive work by treating children who exhibited "traits of character that should serve as warnings to be heeded,"¹³ and he later put his plans into effect in the Henry Phipps Psychiatric Clinic in

¹¹ *New York State Charities Aid Association, Second Annual Report for the Year Ending September 30, 1912*, p. 162.

¹² *Seventh Annual Report of the Committee on Mental Hygiene of the New York State Charities Aid Association for the Year Ending November 1, 1917*, p. 32.

¹³ Adolf Meyer, "What Do Histories of Cases of Insanity Teach Us Concerning Preventive Mental Hygiene during the Years of School Life?", *op. cit.* (Ch. I, n. 36), p. 95.

Baltimore. The first mental hospital clinic to study many children seems, however, to have been the Out-patient Department of the Boston Psychopathic Hospital, which accepted children as patients from the time of its opening in 1912. To its outpatient department children were referred by schools, courts, and social agencies, juvenile and adolescent cases constituting nearly half of its first year's intake.¹⁴ The director of that hospital was Dr. E. E. Southard, an ardent proponent of mental hygiene and closely associated with the work of the National Committee. Clinic work with children was thus a clear outgrowth of the "new psychiatry."

Generally, however, state hospital clinics rarely accepted children as patients before about 1920. The only other notable exception was a clinic opened in 1915 by the Allentown State Hospital in Easton, Pennsylvania. This had as one of its original purposes to serve as a "clearing house for the public schools of all children suspected of being in the exceptional class, securing for them diagnosis and prognosis, determining the degree and variety of mental weakness, advising what environment and course of action will serve the interest of each individual child."¹⁵ It was on the basis of such an interest in educationally retarded children that many of the later state hospital clinics began their work. In Massachusetts and New York, however, the feebleminded were from the beginning recognized as constituting a separate problem, one on which psychiatric consultation was sometimes needed but not in itself a psychiatric question. In the former state a system of "school clinics" was set up in 1919, an outgrowth of the extramural work of the Massachusetts School for the Feebleminded. According to state law, all children three or

¹⁴ L. B. Briggs, M.D., and Collaborators, *History of the Psychopathic Hospital, Boston, Massachusetts*, Boston, Wright & Potter Printing Co., 1922, p. 154.

¹⁵ *Allentown State Hospital, Pennsylvania, Second Biennial Report, 1914 to 1916*.

more years retarded in school must be examined by such clinics, whose staffs are secured from state hospital personnel. In New York, on the other hand, a state Commission for Mental Defectives was established in 1918, its clinics also utilizing some of the state hospital services. This Commission was later combined with the state Department of Mental Hygiene, but in Massachusetts the services for the two types of patients—mentally defective and problem children—have been kept distinct.

CLINICS FOR JUVENILE DELINQUENTS

In the meantime, while mental hospitals were slowly coming to accept a psychiatry that was concerned with the total life of the individual patient, the first psychiatric service planned specifically for children was being worked out under very different auspices. It was in the Juvenile Court of Cook County, Illinois, that Dr. William Healy began in 1909 a five-year study of juvenile offenders and thereby provided the pattern on which the later child guidance clinics were partially modeled. Concerning the beginning of this work, Healy has made the following observations that are of special interest in our search for the origins of child guidance theory and practice:

In 1908, I journeyed about the country on a quest for advice about a program for this new-born idea. I visited medical clinics, juvenile courts and institutions for juveniles; I consulted physicians, educators, psychologists, and others who would seem to be concerned with directing the lives of young people. With the possible exception of Witmer's clinic in Philadelphia where defectives were being observed and the beginnings of Goddard's work with Johnston at Vineland, also with defectives, there was not even the semblance of anything that could be called a well-rounded study of a young human individual. . . . Even physiological norms were not available; standardized mental tests had to be developed—the Binet age level scale had not yet appeared; the importance of knowledge of family attitudes and condition-

ings was barely realized. It was readily discerned that blazing new trails would involve not only research and accumulating new knowledge in separate scientific fields, but also the specific coordination of studies to be undertaken in the realms of medicine, psychiatry, psychology and social work.¹⁶

After five years of private maintenance, support of the clinic was assumed by Cook County, and the clinic was named the Juvenile Psychopathic Institute. Three years later, under the name of the Institute for Juvenile Research, it was taken over by the state and extended to cover the wider field of child guidance.

The contributions of this pioneer project were many. Chief among them was the fact that it brought to the study of delinquency the philosophy which Meyer had been propounding in regard to psychoses. Pronouncing misconduct "a branch of conduct in general"¹⁷ and regarding the child as "the product of conditions and forces which have been actively forming him from the earliest moment of unicellular life,"¹⁸ Healy met each delinquent as an individual and treated each problem as essentially unique. "The interpretations," Healy asserted, "that may be derived from acquaintance with the facts of ancestry, ante-natal life, childhood development, illnesses and injuries, social experiences, and the vast field of mental life lead to invaluable understandings of the individual and to some idea of that wonderful complex of results which we term personality."¹⁹ He used the medical examination to analyze the child's physical assets and liabilities, psychological tests to estimate his intellectual capacity, and psychiatric interviews to determine his attitudes and the character of his mental life. The clinic staff did not include a social worker,

¹⁶ William Healy, "Twenty-five Years of Child Guidance," *Studies from the Institute for Juvenile Research*, Series C, Number 256, Illinois Department of Public Welfare (1934), p. 1-2.

¹⁷ William Healy, *The Individual Delinquent*, Boston, Little, Brown & Co., 1915, p. 28.

¹⁸ *Ibid.*, p. 25.

¹⁹ *Ibid.*, p. 25.

but data concerning the delinquent's personal history and social experiences were secured from probation officers and social agency workers and volunteer investigators. This "four-fold approach" to the study of the delinquent later became a standard practice in child guidance work.

A second program of much the same type was undertaken by Ohio with the establishment in 1915 of the Ohio Bureau of Juvenile Research. The Bureau was made a division of the state Department of Public Welfare and so set a precedent for direct state responsibility in the area of psychiatric and psychological problems of children. Its original purpose was stated as one of investigating, case by case, the causes and motives of juvenile misconduct and working for their eradication or correction, for the sponsors of the Bureau believed that delinquency and crime were largely the expression of "defective or deranged minds" and could be attacked best through the treatment of juvenile offenders.²⁰ Later (in 1912) the services of the Bureau were extended to other wards of the state, to children under the care of social agencies and institutions, and to those living at home with their parents.

In the meantime the problem of delinquency had also aroused the interest of at least one state hospital administrator. In 1916 Dr. George F. Inch of the Kalamazoo State Hospital persuaded the judge of the Grand Rapids Probate Court (which had jurisdiction over delinquents) and the county commissioners to pay the traveling and maintenance expenses of a clinic that would examine children on referral from the court. This plan was later taken up by other hospitals in the state. The work, however, never approached the comprehensiveness of Healy's studies nor was much beyond diagnostic service offered.

²⁰ Edmund M. Baehr, "The Bureau," *Quarterly Bulletin of the Managing Officers' Association*, Ohio Department of Public Welfare, June 1931.

THE DEMONSTRATION CHILD GUIDANCE CLINICS

Such, then, was the status of psychiatric service for children around 1921, when the National Committee for Mental Hygiene was laying plans for what later came to be called child guidance clinics. That program also developed partly out of an interest in juvenile delinquency, as representing one specific group of children whose maladjustment boded ill for their future. It has been shown in the previous chapter how mental hygiene, that originated as a movement for improving conditions for care and treatment of psychotic individuals, came to this point of view. Meyer had long been convinced of the value of child study and since 1903 had been actively connected with work with teachers and parents.²¹ The Freudians, on the other hand, were led by their theories of the early origin of most mental maladjustment to see in childhood, as White put it, "the golden age of mental hygiene." The work of both groups with psychotic patients had reinforced their convictions about the preventability of much mental suffering. As Frankwood Williams' retrospective account shows, the observations that were first made regarding psychotic individuals were confirmed by studies of other maladjusted people, so that mental hygiene became increasingly concerned with the problems of children.²²

Tracing back the history of our cases as they came to the hospitals for mental disease, in the process of gathering data that might help us in the prevention of mental disease, we found, of course, that these illnesses rarely developed suddenly, but that they had been developing over a long period of time, and reached into childhood, where in many instances the unhealthy development was sufficiently marked to have attracted the attention of a trained person had one been about.

²¹ Adolf Meyer, "The Birth and Development of the Mental Hygiene Movement," *Mental Hygiene*, Vol. XIX (1935), p. 29-37.

²² Frankwood E. Williams, "Finding a Way in Mental Hygiene," *Mental Hygiene*, Vol. XIV (1930), p. 225-57.

Working with adult delinquents, or with adolescent delinquents, we seldom found that the delinquency was a recently developed or isolated matter, but merely an incident in a long series of delinquencies leading back into school life and childhood. If we studied problems of dependency, we seldom found that the present need had suddenly developed and was something new. Sometimes, of course, it was due to accident and illness, but more often an inability to maintain themselves, a dependence on others, had always been more or less in evidence from the time of childhood. If we studied the employment turnover and industrial unrest and dissatisfaction and inadequacy, again we found ourselves dealing, more often than not, with individuals who during childhood and since childhood had found it difficult satisfactorily to adjust themselves to group living. We came to the belief, therefore, that in dealing with these several problems, we were not, as a matter of fact, dealing with several separate problems but with one problem with different manifestations. What actually we had to deal with, whether it was in the field of functional nervous and mental disease, delinquency, dependency, industrial unrest, was social maladjustment, due to faulty emotional development, which had its roots in childhood. For the sake of practicable work it might be necessary to break this problem into its several parts, but in our thinking, planning, and developing of social concepts, we found it would be well for us to think not so much in terms of the prevention of nervous and mental disease, the prevention of delinquency, the prevention of dependency, the prevention of industrial unrest, as in terms of emotional development and maladjustment.²³

The National Committee for Mental Hygiene played an important part in the war and post-war work with shell-shocked soldiers and later had a brief period of special concern with the problems of college students and industrial workers. Starting about 1917, however, its interest became particularly centered upon the mental hygiene aspects of crime, feeble-mindedness, and poverty. Numerous surveys were made, and in 1921 a clinic program designed to demonstrate a method of checking juvenile delinquency was

²³ *Ibid.*, p. 237-38.

financed by the Commonwealth Fund. Describing the purposes of these clinics an early report²⁴ stated:

As a result of . . . studies, the conviction is spreading that an adequate understanding and treatment of the personality difficulties of children not only offer the possibility of early discovery and prevention of delinquent trends but may also mean in many cases the removal of conflicts and the cure of habits likely to lead to unhappiness, inefficiency, and failure in adult life. [The purpose of the Commonwealth Fund clinics is] to develop the psychiatric study of difficult, pre-delinquent, and delinquent children in the schools and juvenile courts; to develop sound methods of treatment based on such study; and to provide courses of training along sound lines for those qualified and desiring to work in this field.

In planning this program the National Committee drew upon the experience of the Illinois Institute for Juvenile Research, the Judge Baker Foundation, and two psychopathic hospitals. After the first two it patterned its use of the psychiatrist and the psychologist for treatment and its plan of working through the juvenile court. Precedent for including psychiatric social workers on the clinic staff was offered by the Boston Psychopathic Hospital and the Henry Phipps Psychiatric Clinic, both of which differed from the Institute also in serving the whole community rather than merely the court. The Committee had already taken part in the training of psychiatric social workers, and its clinical program was in a sense a putting into practice of much that had been taught.

The first demonstration clinics were set up in 1922 in St. Louis and Norfolk with the purpose of "showing the juvenile courts and child-caring agencies what psychiatry, psychology, and social work have to offer in connection with the treatment of the 'problem child'; and by properly directed and effective methods of treatment not only to help the indi-

²⁴ *Commonwealth Fund Program for the Prevention of Delinquency, Progress Report*, New York, Joint Committee on Methods of Preventing Delinquency, 1926, pp. 7, 8.

vidual delinquent to a more promising career but . . . to decrease the amount of delinquencies."²⁵ It soon became apparent, however, that there were disadvantages to working wholly through the courts and that the most effective preventive work was to be done with children whose misconduct had not yet been accounted legal delinquency. The later clinics were therefore established in connection with hospitals or schools, and referrals were sought from parents, teachers, and social workers.

FINDINGS OF THE DEMONSTRATION PROGRAM

Stevenson and Smith²⁶ record in detail the development of child guidance theory and practice during the demonstration period and later. Demonstration clinics, conducted from six months to two years by a staff sent out from New York, were held in seven widely scattered cities. Out of their experience certain conclusions emerged that form the basis for much of the child guidance work of today. One of the earliest was that which is now a commonplace: that child guidance should not be limited to any one diagnostic group, such as delinquents or "pre-psychotics," and that it has most to offer to children of adequate intelligence whose difficulties have not been of too long duration.

The theory that clinics should find a means of distinguishing and then treating all maladjusted children was put to test in connection with a health survey in Monmouth County, New Jersey. There it was found by investigators that thirty-nine per cent of the children in the public schools needed further psychiatric study and treatment. A demonstration clinic unit, consisting of psychiatrist, psychologist, and psychiatric social worker, worked in the county for about a year and

²⁵ Lawson G. Lowrey, "The Child Guidance Clinic," *Childhood Education*, Vol. I (1924), p. 100.

²⁶ George S. Stevenson and Geddes Smith, op. cit. Much of the material in this chapter was secured from that book.

showed conclusively that need for psychiatric help is not the only factor determining amenability to treatment. The full implications of the failure were perhaps not seen at that time. Emphasis was put upon the magnitude of the problem and the lack of community facilities to carry out the treatment program, and the individual families' attitudes toward the treatment of their children were largely attributed to rural outlook rather than to variation in the desire for psychiatric help.

The discovery that child guidance clinics cannot work apart from the community and must depend upon other social agencies and institutions for assistance in their work led to further conclusions about child guidance work. On the one hand, this finding was held to indicate that clinics should work with schools and social agencies and "interpret" child guidance to them. On the other, it showed that the community had a part to play in the promotion of children's mental health; that the work of a clinic was seriously handicapped unless there were in the community fairly adequate facilities for the care of children with respect to education, health, and recreation, and some special provisions for children who were mentally defective, or dependent, or delinquent. Without these resources, plans for environmental treatment could not be carried out effectively, nor could psychotherapy compensate for gross defects in the community situation. Equally or more important were found to be the attitudes of those in charge of such agencies and institutions. Child guidance, accordingly, came to be regarded as a cooperative enterprise, one that drew upon many more than the clinic staff for its undertaking.

Not only were the clinics dependent upon community facilities for making possible their treatment program and upon an understanding of their viewpoint by other social workers, judges, teachers, and the like for carrying it out, but it be-

came increasingly clear that the demonstration clinics could not hope to cope with all the mental hygiene problems of children that would be brought to their attention. There was continually the possibility—an actuality at times—that they would have more patients than they could treat. They could not work without community support, and yet community support, once attained, threatened to swamp them with patients.

The clinics' policy of education and cooperative work was an attempt at the resolution of that dilemma. Again and again Stevenson and Smith point out that clinics can serve "only a handful of children," that even a small community can impose upon a child guidance clinic an immense job, and that "to give intensive care to more than a selected minority of all the children who might profit by it is a physical and economic impossibility."²⁷ "Education" was held to be the solution. Most clinics therefore allotted a considerable proportion of their time to teaching the principles of mental hygiene to teachers, school nurses, court and other social workers, and to parents as well. Education of social workers and others through case conferences, exchange of staff, and "co-operative work" was a more direct attack on the problem, it being expected that what these workers learned about the treatment of a few children could be applied to their work with the many who would otherwise need the clinic's help.

PRESENT CLINIC SERVICES

Through the demonstration clinic experience, a form of clinic and mode of operation were worked out that have been followed by many urban child guidance clinics ever since. Typically, a child guidance clinic staff consists of psychiatrists, psychologists, and psychiatric social workers in the ratio of 1:1:2 or 3, and sometimes includes a pediatrician as well.

²⁷ *Ibid.*, pp. 2, 33, 54.

The objective of such a clinic is held to be "bettering the adjustment of children to their immediate environment, with special reference to their emotional and social relationships, to the end that they may be free to develop to the limit of their individual capacities for well-balanced maturity."²⁸ In other words, child guidance clinic staffs no longer think primarily in terms of prevention but are interested in helping children with their present problems for the sake of present satisfactions. To this end the clinic offers its social, psychiatric, and psychological services to children and their parents and, in addition, usually carries on a program of education designed to spread a knowledge of mental hygiene throughout the community.

For the most part such clinics receive their patients through the medium of social agencies (including courts and schools), though referrals directly from parents form a considerable part of the intake of some clinics. Once well established, the clinics tend to exclude from service or to give only limited service to children suffering from extreme mental defect or neurological handicaps, and they refer to private physicians or to hospital clinics the children whose difficulties are traceable to physical causes. The methods of psychiatric and case work treatment used in the clinics vary considerably²⁹ but few, if any, clinics confine their work chiefly to diagnosis.

Although child guidance workers have thus developed a fairly definite body of principles and practices, it would be far from correct, however, to imply that theirs is the accepted mode of functioning in psychiatric clinics in general. As later chapters will show, there is considerable diversity among clinics, much of which is traceable to the theories of psychiatry under which they operate and the purposes which they serve. Other differences among clinics derive from the aus-

²⁸ *Ibid.*, p. 53.

²⁹ See Chapter XII for a detailed analysis of current theories and trends.

pices under which they are conducted, the geographical areas in which they operate, the training and interests of the staff members, and other factors of less general importance. These diversities and their effect upon the provision of psychiatric service for children, particularly for those living outside of metropolitan areas, will be discussed in the following section of this book.

As background for that analytic study we need to summarize the few available statistics so that the present situation with respect to the extent of psychiatric service for children can be visualized. The most recent figures for the country as a whole are those that were collected by the National Committee for Mental Hygiene³⁰ in 1935, but there is no question that the present situation (1939) is very similar. At that time 617 community clinics³¹ that accepted children as patients were located. This marked an increase of 147 over the number reported in 1927, in spite of the fact that the economic depression of the 1930's had resulted in the curtailment or elimination of psychiatric programs in some cities and states. These clinics had an intake of about 100,000 new patients annually but it was not known how many of them were children, since many clinics examined adults as well.

Many of these clinics were conducted in ways that differed considerably from those of child guidance, as subsequent chapters will show. Some indication of the proportion that followed child guidance methods is given, however, by the figures regarding staff composition. The clinics that reported having a "threefold staff"—that is, one composed of psychiatrist, psychologist, and social worker—numbered 235 (thirty-eight per cent of the total clinics), and 141 of them were

³⁰ "Directory of Psychiatric Clinics in the United States, 1936," *Mental Hygiene*, Vol. XX (January 1936), p. 72-129.

³¹ The term, community clinic, is used to describe clinics open to the general public and excludes those conducted for patients on parole from institutions, for institutional charges only, or for other special groups, such as college students.

located in cities with a population of 100,000 or more. The remaining ninety-four (and some of the 141 as well) were served by traveling staffs that gave intermittent service to a group of communities. The stationary child guidance clinic was restricted to large cities, and no city under 150,000 population had a full-time clinic of that type.

The immediate cause of that situation was doubtless the financial cost. A child guidance unit, including secretarial assistance, costs about \$20,000 a year and customarily treats from three to four hundred new patients annually.³² Clinics of this type are frequently financed by private funds, and the likelihood of a "community chest" setting aside that amount of money for child guidance varies with the size of the city. This in itself, however, is probably a reflection of the esteem in which mental hygiene is held, for it seems likely that that amount of money could be raised in small cities if mental health was considered very important and the possibility of its furtherance through clinic work appreciated.

Such reflections raise the question of the usual sources of financial support of psychiatric clinics. The 1935 census showed that about thirty per cent of the clinics were financed by private funds and sixty per cent by funds supplied by state governments. More than half of the remaining clinics received their support from municipalities, while county governments financed twenty-nine clinics and the federal government three. The number of clinics in the various states, the source of their financial support, and the number of psychiatric hours available weekly are shown in Table I. There it is seen that psychiatric clinics were very unevenly distributed. Fifteen states had no clinics, and in nine others (including the District of Columbia) the state government made no financial contribution to psychiatric work with children. New York provided 209 clinics for a population (child and adult)

³² George S. Stevenson and Geddes Smith, *op. cit.*, p. 55.

TABLE I

Hours of psychiatric service and source of financial support of clinics attending children as patients in the various states in 1935

	Total Hours of Psychiatric Service Avail- able Weekly*	Number of Clinics and Source of Financial Support		Total
		State Government	Other Sources	
California	252.5	5	22	27
Colorado	80.0	2	2	4
Connecticut	158.0	1	7	8
Delaware	42.0	8	1	9
District of Columbia	81.0	—	5	5
Georgia	4.0	—	2	2
Illinois	667.5	21	16	37
Indiana	3.5	—	2	2
Iowa	43.0	1	1	2
Kansas	6.0	—	2	2
Kentucky	48.0	—	2	2
Louisiana	46.0	1	2	3
Maine	1.5	1	—	1
Maryland	478.5	8	6	14
Massachusetts	667.0	56	10	66
Michigan	384.5	20	7	27
Minnesota	103.0	1	5	6
Missouri	86.0	—	7	7
Nebraska	10.0	1	—	1
New Hampshire	10.0	6	—	6
New Jersey	224.5	23	16	39
New York	2,301.5	143	66	209
North Carolina	26.0	—	2	2
Ohio	342.0	6	17	23
Oklahoma	41.0	3	—	3
Oregon	8.0	2	—	2
Pennsylvania	625.0	44	25	69
Rhode Island	83.5	2	7	9
South Carolina	17.5	10	—	10
Tennessee	17.5	—	1	1
Texas	125.0	—	6	6
Virginia	94.0	3	2	5
Washington	38.0	2	2	4
Wisconsin	62.0	3	1	4
Total	7,177.5	373	244	617

* Includes hours in 35 clinics serving adults only and excludes 28 clinics that did not report on this question.

of about twelve and a half million, while an equal number of people lived in states in which there were no clinics at all. California and Texas with populations nearly half as large as

New York had twenty-seven and six clinics, respectively, while Massachusetts had sixty-six clinics for about four million people.

The standard currently used by the National Committee for Mental Hygiene is one full-time, threefold clinic for every 200,000 population. Since so many of the clinics listed in Table I were not of that type, however, calculation of adequacy on the basis of number of clinics greatly minimizes the situation. A more satisfactory indication of the extent of psychiatric service available in clinics for children (or for children and adults) is given by the number of hours of psychiatrists' time devoted weekly to this work. In seven states with a combined population of 13.8 million this was less than ten hours per week apiece. In contrast, the somewhat equal number of people in New York state had 2,300 hours of psychiatric service weekly or about one hour per 5,400 people. One can find in the table many other examples of discrepancies between states, but this one is probably sufficient to substantiate the main conclusion that clinical psychiatric service for children is unevenly distributed and is inadequate in most states.

The other conclusion that Table I suggests—that state governments are the chief source of financial support for clinics—is found to be incorrect when hours of service rather than number of clinics is made the basis of comparison. State governments did finance sixty per cent of the clinics but those clinics provided only twenty-three per cent of the total hours of psychiatric service. On the other hand, state-financed clinics tended to serve small cities and towns (more than eighty per cent of them served communities of less than 100,000 population) while privately-financed ones were chiefly confined to metropolitan centers. With respect to this latter point an analysis of the figures⁸⁸ shows that all of the thirteen cities with a population of 500,000 or more had at

⁸⁸ Compiled by Mary Augusta Clark for the National Committee for Mental Hygiene.

least one threefold clinic serving either children only or children and adults, and in all but one of them at least thirty hours of psychiatric service per week were given.⁸⁴ In the next group of twenty-four cities with a population between 250,000 and 500,000 only half had a threefold clinic offering so much psychiatric service, but three cities had clinics with ten or more hours of psychiatric service a week, and two had clinics offering less than that amount. Among the fourteen cities with a population of between 150,000 and 250,000 there were five with full-time clinics, two others with ten to thirty hours of psychiatric service, and one with less than that amount of service in its clinic. In the last group of cities (the forty-two with a population of from 100,000 to 150,000) there were no clinics offering full-time service, five cities had clinics with less than thirty psychiatric hours a week, and ten had clinics with less than ten hours of a psychiatrist's time. In other words, full-time, threefold clinics accepting children as patients existed only in cities of over 150,000 population and were infrequent in cities of less than 250,000.

Another way of looking at the question of the adequacy of the present clinic services is to consider the ratio of psychiatrists to total population. The National Committee for Mental Hygiene, on the basis of the preceding figures, estimates that large cities can support one full-time clinic for each 200,000 population.⁸⁵ Such a clinic can give "intensive" service to about 250 children and 300 adults annually. Outside of the cities which have such clinics, however, live over 86,000,000 people. To give them the amount of psychiatric service that is available to the residents of many large cities would require 864 psychiatrists who, working at the rate of

⁸⁴ There were fourteen such clinics in New York and five in Boston. Clinics offering thirty hours a week of psychiatric service were considered full-time clinics.

⁸⁵ This estimate is made in the *Hospital Survey*, 1936. It is an empirical estimate, based on the experience of large cities, and uses financial capacity and not the community's need as its basis.

38.5 hours per week (the standard used in a recent New York hospital survey) would give 33,264 hours of service. Actually, the figure of psychiatric service available to these people in December, 1935, was 1,200 hours, so, according to these standards, the population living outside of large cities received less than four per cent of the service probably available to them had they lived in large cities. Such a figure cannot be taken very literally of course, but regardless of the margin of error in the original standard and regardless of the extent to which environmental conditions may be held to favor the resident of the smaller community, it seems obvious that most of the country is very inadequately supplied with psychiatric service.

The statistics of clinical facilities thus lead to two main conclusions. On the one hand, child guidance clinics (and their attendant philosophy and working methods) are confined mainly to large cities, and, on the other hand, state governments provide the chief source of revenue for psychiatric service to children in small towns and rural areas. The cleavage is not exact, but such is the picture in broadest outline. If, therefore, it is granted that child guidance workers have much to contribute to the promotion of mental health and it is desired that their type of service be made available to larger numbers of children who live outside of metropolitan areas, the means would seem to lie in the extension of state-financed services and the incorporation of the child guidance viewpoint into state-financed work. So stated, the task might appear to be simple, but that is far from the case. Before satisfactory plans can be drawn up, there is needed, on the one hand, an intimate knowledge of state-financed clinics (particularly of those that serve rural areas) and, on the other hand, a clear understanding of the essential attributes of child guidance work. Neither of these requirements (particularly the first) can be adequately met at present but it is the main

purpose of this book to assemble and analyze the available data so that a start in the direction of effective planning can be made.

To this end we shall describe first the auspices under which state-financed clinics are conducted, analyze in some detail the work that is carried on, set forth the common problems that are found among the clinics, and attempt to find some of the sources of difficulties. In the light of the experience of state-financed clinics we shall attempt next a restatement of child guidance theory and principles, especially as they have developed in the years since the demonstration clinics were in operation. The problems encountered in state clinics and the findings of later-day child guidance workers will thus be brought into juxtaposition, and the implications of one for the other be discussed. Since such an analysis requires the presentation of much detailed data about the state-financed clinics, it may be that some of the following chapters will be of little interest to readers who are concerned chiefly with the broad lines of development and general principles. To such readers we suggest omitting Chapters V to VIII and proceeding directly to Chapter IX, where the main findings of the analysis of the state clinics' problems are stated.

II

A Survey of State-financed Clinics

CHAPTER FOUR

Sources and Plan of the Study

THOSE who would draw up plans for making competent psychiatric service available to children who live outside large cities have complicated questions to answer before they can proceed effectively. First of all, like those who are in charge of planning urban programs, they must form an opinion as to the essential characteristics of fruitful work—what kinds of service it is necessary to offer if a clinic is to be helpful to a considerable proportion of its patients; what this entails in the way of staff and their preparation for professional duties. Back of that they need to know something of the main cleavages among current schools of psychiatric thought and the theoretical considerations from which they proceed, for while administrators cannot hope to evaluate which set of theories is most nearly correct, they must be aware of the fundamental differences among groups of professional workers if they are to choose intelligently and avoid one of the main sources of internal friction.

In addition to this, those who plan rural programs must become informed about the peculiar characteristics of service outside metropolitan areas, the ways in which clinics have been set up there, what manner of success they have achieved, and what difficulties they have encountered. In Part I of this book we have attempted to throw some light on the first of this series of questions, and further pertinent material will be presented in Part III. The present section (Part II) is concerned chiefly with the questions about non-metropolitan clinics, for it has seemed that an understanding of this situation is needed before the applicability of recent findings to rural work can be profitably considered.

So far the task of providing psychiatric service to children who live outside metropolitan centers has been assumed almost wholly by state-financed agencies (mental hospitals, departments of state governments, university medical schools, and the like), and at present there appears to be an increase of interest on the part of both state and federal governments in this problem. For this reason the most satisfactory source of information about non-metropolitan clinics would seem to be state-financed psychiatric services. As the previous chapter has shown, such clinics constituted sixty per cent of the total clinics in the country in 1935 and provided about a fourth of the total hours of psychiatric service. They were scattered through twenty-five states and varied widely in the extent and character of their services. It seemed therefore that a study of their organization, modes of functioning, and experiences in attempting to give psychiatric service under extremely diverse conditions would be most instructive.

In undertaking such a study, however, we were met by the fact that state clinics do not confine their work wholly to non-metropolitan areas. Nor did it seem feasible to limit our analysis to the clinics that did meet in such centers, for it was found that some of the most suggestive leads to the characteristics and sources of difficulty of non-metropolitan clinics appeared when the work of clinics in large and small cities was contrasted. Accordingly, our study, which aimed originally at discovering the achievements, problems, and peculiar characteristics of rural psychiatric work, was broadened to include all state-financed psychiatric clinics for children. Nevertheless the original emphasis was not lost sight of, and except for a few examples that seemed historically or technically interesting, the clinics selected for study were chosen because of their bearing on the problems of psychiatric work with children who do not live in large cities.

SOURCES OF DATA AND BASIS OF CLASSIFICATION

The material for the study came from several sources. First, there was at hand a large collection of material about state-financed clinics that was gathered by Miss Winifred Arrington and Miss Dorothy Brinker, who, under the auspices of the National Committee for Mental Hygiene, had made first-hand studies of the work of the most important clinic systems. They visited the central and local offices, talked with directors, staff members, and professional and lay people in the communities in which the clinics operated, studied the statistics and other reports, and prepared analytic surveys of the work of the clinics. Their main investigations were carried on between 1930 and 1932 but contact with numerous clinics was maintained during the following five years. In addition, they collected by correspondence less detailed material about the smaller programs, so that there were at hand in the files of the National Committee some data about almost all the state-financed clinics that were in existence in the United States in that period. The value of this material lies in the fact that it offers a picture of typical clinics and the situations they encountered in attempting to provide psychiatric service to children. The passage of time since the investigation was carried on has therefore not invalidated the significance of the information relative to methods of administration, problems of staff cooperation, relations of clinic to community, the purpose of treatment, questions of function, and many other matters to be discussed in these pages.

Supplementing the 1930-1932 report, the National Committee's regular files contained additional information about more recent developments. This was drawn upon only slightly, however, for it was not our aim to produce a comprehensive, census-like survey. Annual reports and descriptions of proposed programs do not provide adequate data for

a study such as ours, for what is needed is more intimate information about day-to-day experiences that can be obtained only through personal contact or through reports of investigations that have had that general purpose. Some such material, supplementing that collected by Miss Arrington and Miss Brinker, was provided by articles published in psychiatric journals and by the writer's own long contact with many of the most important of the state-financed clinics. Finally, statistical information about the total situation was at hand in the form of the original returns for the National Committee's 1935 census of psychiatric agencies.

With such a mass of material at hand, the question of deciding which approach would be most likely to yield fruitful results was a difficult one. A cursory survey of the data showed that the state-financed clinics ran the whole gamut of possible psychiatric services as at present conceived. The work of the great majority of them consisted of examining feeble-minded or neurologically handicapped children for the purpose of diagnosis and possible commitment to institutions. Others sought to serve so-called problem children of relatively adequate intelligence; to them they gave help that ranged from advice to parents, teachers, and others to long-continued psychiatric treatment. Among these latter clinics were a few that were scarcely distinguishable from the privately-financed, urban child guidance clinics, while others attempted to combine the child guidance philosophy with the usual state-hospital working methods. Detailed analysis revealed that these differences were highly important in accounting for the reception which the clinics met in their communities and for the relative effectiveness of their services—although it must be acknowledged at the outset that our information about this latter important aspect of the work was meager at best. Nevertheless, it did not seem feasible to make type of service the primary basis on which to divide the clin-

ics for purposes of discussion, since exact classification of clinics on this point seemed impossible.

Another important basis for division was found in the size of the communities in which the clinics operated. It has been noted in the previous chapter that the great majority of state-financed clinics are held in towns of under 100,000 population. Small-town and rural areas obviously set conditions for clinic work that are different from those encountered in large cities. The total number of individuals to be served may be smaller but the area from which they come (in so far as state clinics work on a county or district basis) is usually larger. The social and economic situation in which the majority of the patients live tends to be considerably different also, and people are less likely to be accepting of psychiatric assistance, if only because there is more publicity attached to attending a clinic in a small town than one in a city. Then, too, social resources for assisting a clinic in its treatment work are less abundant in rural areas, and, on the other hand, social and educational organizations make demands on clinics for services that are provided under other auspices in metropolitan centers.

For these and other reasons it might have seemed most satisfactory to divide clinics on the basis of the size of the communities in which they were held, but this did not prove to be feasible. The chief difficulty lay in the fact that frequently a unit sent out by a state hospital or a state department served communities of greatly varying sizes. The clinics of the Greystone Park State Hospital (one of the most interesting clinic systems), for instance, met both in large cities, such as Newark and Jersey City, and in small communities in Sussex and Warren counties. In such situations the value of studying the large-city clinics seemed to lie chiefly in discovering the differences that a similar staff found in their work in large and small communities—findings which

would be obscured if the large-city clinics were studied as a separate group. Actually, too, it was found that our data were frequently not adequate for exploring these questions in detail, so they were made a minor point of consideration in the study as a whole.

Other aspects of the state clinics' heterogeneity were found in the distinction between stationary and traveling clinical units and in staff composition (some clinics had threefold staffs, others had various twofold combinations, and many had only a psychiatrist in attendance), as well as in that much more important consideration, the psychiatric theory from which services and treatment methods proceeded. The first two would have provided a clear-cut but not very instructive basis of classification, while the latter would probably have gone to the heart of many problems but was not susceptible of exact definition.

Such being the case, it seemed best to discard bases of classification that might have led directly into the consideration of specific phases of clinic work and to choose instead one that cut across many important lines of difference but that did have practical importance for those who would plan programs. This basis for division of clinics was found in the administrative authorities under which the clinics operated. Nor did this prove to be a merely mechanical way of breaking down the clinics into groups that were small enough to be handled reasonably well, for closer study revealed that the objectives, working conditions, methods, and problems of many clinics grew directly out of the administrative situation.

AUTHORITIES ADMINISTERING STATE-FINANCED CLINICS

The authorities administering clinics financed by state funds range from individual mental hospitals which conduct occasional clinics in the hospital buildings to departments of the state government set up specifically to provide mental

health services. The promotion of mental health is regarded as a function of such diverse authorities as public welfare, public health, and education, not to mention those specifically set up to provide care for the mentally ill. Nevertheless few, if any, authorities have assumed responsibility for maintaining a comprehensive system of clinics that aims to meet mental health needs on a statewide basis. Instead, some regard their clinics as demonstrations or experiments, others emphasize their research value or their educational function, and others limit the clinics' services to certain specified groups of patients.

In spite of this considerable range in administrative authorities, the great majority of state-financed clinics are maintained by individual state hospitals. Most of these clinics started as (and many of them still remain) informal services of the hospitals, through which psychiatric examinations of children were occasionally made by staff members. Some hospitals made it a practice to set aside certain hours each week or month in which such services to adults and children would be offered, the patients on parole from the hospital usually attending the same clinics. The further steps in the process of differentiation followed naturally. Psychological examinations were added to the psychiatric. Social investigations were sometimes made by members of the hospital social service staff. Some hospitals arranged for quarters in towns in the hospital area and sent to them variously-composed traveling clinics at regular intervals. In some places a distinction between paroled and other patients was made, and separate clinic days were set aside for the two groups. In others, separate clinics for children were maintained, although, for the most part, they were manned by the same staff as the other clinics of the hospital. One hospital, however, set up a stationary, full-time child guidance clinic with its own staff. From this diversity in practice it is clear that the aims of state

hospital clinics are variously conceived by their administrators. Usually the aim is expressed as that of "serving the mental health needs of the hospital district," but what is included under that conception varies greatly, even among the hospitals of a given state.

For the most part these state hospital clinics are directed solely by the superintendents and governing boards of the individual hospitals. Five states, however, maintain some slight measure of central control over them. In Delaware, for instance, the single state hospital, which has a wide-reaching program of extramural service, has itself become by law almost the equivalent of a department of mental health. In Massachusetts there is central direction of the traveling clinics for retarded school children (which are conducted by the state hospitals in addition to their mental hygiene clinics), in that standard forms of procedure and statistical reports are issued by the Division of Mental Deficiency of the Department of Mental Diseases. New Jersey's control over the clinics that have their headquarters in three state hospitals consists of a partial standardization of statistical recording and reporting by the Department of Institutions and Agencies.

In New York and Massachusetts the central mental hygiene authorities offer advice and guidance to state hospitals initiating programs and maintain demonstration or supplementary clinics of their own. Pennsylvania's Bureau of Mental Health in the Department of Public Welfare can be included with the New York and Massachusetts systems here, for the objectives of the three states have much in common. Stated most generally, the aim of these central departments is to stimulate the state hospitals to activity in child psychiatry and to coordinate and supplement their clinic efforts.

In several other states central departments of the government have provided clinics for the psychiatric examination of children who are wards of the state. Virginia and Rhode

Island are examples of this type of service. The Virginia program began in 1929, when the Bureau of Mental Hygiene was added to the Department of Public Welfare. Before that time the Children's Bureau of the Department of Public Welfare had secured psychiatric examinations for its wards (delinquents chiefly) through privately-supported clinics. A fully-staffed child guidance clinic was set up in Richmond, and a mobile service to Roanoke, Norfolk, and Danville was undertaken. The clinic's facilities were greatly curtailed in 1931; up to that time Children's Bureau cases had occupied most of the clinic's attention.

The Rhode Island situation is very similar. In 1932 the Psychiatric Clinic was added to the bureaus and institutions responsible to the Public Welfare Commission. It offers diagnostic and consultation service to the state institutions and to the Placement Bureau, which has charge of delinquent and dependent children in foster homes.

The centrally administered clinics of Ohio, Illinois, and California have been directed, in part at least, toward the prevention of delinquency. The Ohio Bureau of Juvenile Research, previously described,¹ was set up under the Department of Public Welfare in 1913 for the purpose of "investigating the causes and motives of juvenile misconduct or delinquency with the ultimate idea of correcting and eradicating them."² It is like the clinics of Virginia and Rhode Island, however, in confining its services chiefly to wards of the state, although for eight years it did conduct numerous traveling clinics as well. In Illinois the Institute for Juvenile Research, whose early history has been described in the previous chapter,³ is an undertaking of the Division of the Criminologist in the Illinois Department of Public Welfare. Originally set up as a research project and later taken over by the Cook

¹ Chapter III, p. 48.

² Edmund M. Baehr, *op. cit.*

³ For further details see Chapter III, p. 46-48, and Chapter VIII, p. 212-229.

County Juvenile Court, the Institute for Juvenile Research has for years had the additional aims of providing communities with assistance in the field of child guidance, training personnel for work in these fields, and carrying on research. The California program was patterned after that of Illinois but has never had as adequate finances or staff or received the same degree of public support.

Very different from the systems of these latter states, both administratively and in major objective, are those that are maintained, directly or indirectly, by state departments of education. Within this administrative group several differences are found. There are, first of all, the rather small psychiatric clinics conducted by university hospitals.⁴ Like the rest of such hospital services, their primary aim is to provide facilities for training medical students and for research. Clinics of this type have been set up in the university hospitals of California, Minnesota, Nebraska, Washington, and Wisconsin. In addition to such work, the Indiana University School of Medicine assisted temporarily in financing a child guidance clinic for the community but made only partial use of it for student training, while in Kentucky and Oregon the Departments of Psychiatry have established more elaborate child guidance services.

Then there are three states in which the psychiatric service of the university medical school has been set up more elaborately. Michigan, Iowa, and Colorado, with well-equipped psychopathic hospitals operating in conjunction with their medical schools, have experimented not only with comprehensive outpatient work but, to some extent, with extramural service as well, the Michigan hospital lending a staff for a clinic project in Detroit, and the Iowa and Colorado institu-

⁴ In some of the states listed below the state university is not administered by the state department of education, but the clinics are nevertheless grouped together here because further refinement of categories necessitated unwarranted detail.

tions having engaged at times in "mobile" programs. In these latter states—particularly Colorado,⁵ and, more recently, Oregon—the universities have added to their usual teaching and research objectives that of attempting to meet the general mental hygiene needs of the state. This is viewed as part of the university's legitimate extension-service function, but it seems unlikely that sufficient funds will ever be put at a university department's disposal to carry out that objective.

In other states the department of education has more directly sponsored some psychiatric work with children. These services have been almost wholly of the intelligence-testing type, with some slight attempt at providing for the psychiatric examination of a few doubtful cases. In Connecticut, for instance, the Division of Special Education and Standards in the Department of Education has, from time to time, considered combining psychiatric service with its main function of giving psychological tests. At present, however, the examiners refer doubtful cases to private mental hygiene clinics. New York, on the other hand, in 1930 attached a psychiatrist to the Bureau of Medical Inspection in the Department of Education. So far, the duties of this special member of the staff have been incidental to a program of general mental hygiene education, and the cases referred to him for professional observation are few and miscellaneous in type. Similarly, the psychiatric work of the California Bureau of Mental Hygiene in the Education Department's Division of Special Education and its Bureau of Correction of Speech Defects and Disorders has consisted almost wholly of mental hygiene education.

Also under the general supervision of state departments of education are those arrangements by which psychology departments of state universities or teachers' colleges give mental tests or other psychological services to children in nearby towns and state institutions. In North Dakota, for example,

⁵ The Colorado clinics are described in Chapter VI.

much of the impetus toward the study of difficult children has come from the psychology department of the state university. For some time the director of this department furnished psychological service to communities on request and, in 1931, cooperated with the State Children's Bureau and the two state psychiatric institutions in a threefold clinic program. In Georgia a member of the psychology department of the University of Georgia at one time gave mental tests to school children and has worked with a psychiatrist from the Mill-edgeville State Hospital in a mental hygiene clinic. At the University of California a professor of psychology (who is also a physician and professor of pediatrics in the medical school) and her students have taken part in several clinic projects in San Francisco, Berkeley, and Oakland.

As to the teachers' colleges, two of the six New Jersey institutions (those in Newark and Montclair) have, at one time or another, employed a staff of psychologists, psychiatrists, and social workers to treat directly or on a consultation basis students or model-school pupils. In California the personnel department of the San Jose State Teachers College, representing psychologists among others, has occasionally collaborated with psychiatrists from the adjacent state hospital at Agnew in conducting a local clinic for children and adults, and, at other times, has given psychological service to the schools of San Jose. All these efforts, however, are quite far removed from comprehensive psychiatric services and are noted here chiefly to indicate another source from which such programs might develop.

Another possible but as yet infrequent authority administering psychiatric clinics for children is the state department of health.⁶ As long ago as at the founding meeting of the National Committee for Mental Hygiene in 1909 it was sug-

⁶ In Canada all the mental health work of the provinces is carried on under such auspices.

gested that mental hygiene work might well be carried on under public health auspices,⁷ but to date only four states have made such provisions. Maryland has conducted a few clinics under the joint supervision of the Board of Mental Hygiene and the Board of Health. In Georgia the State Board of Health is the sponsor of clinics by reason of its supervision of the Training School for Mental Defectives, by which clinics have occasionally been provided. Indiana's program is a very new one. A department of child psychiatry was established in connection with the Indiana State Board of Health late in 1937, the plan being to carry on work through the University Medical School, the Children's Division of the Department of Public Welfare, and the Department of Public Instruction. This combination of state departments should make Indiana's clinic program of particular interest.

The Division of Mental Hygiene in the Connecticut Department of Health was until recently the only state public health authority to provide a psychiatric clinic program. This Division, whose functions have never been legalized or defined with any precision, has at different periods either sponsored or cooperated with other agencies in providing community mental hygiene clinics. Early in its career (it was established in 1921) the Division financed a psychological testing service for dependent children who were wards of the state. At a later date it provided psychiatric social workers to work with state hospital psychiatrists in community clinics, and recently, with a full-time psychiatrist as director, it has organized community clinics of its own. Throughout, these services have constituted one phase of a more inclusive educational program, which appears to have been the Department of Health's chief aim in creating a division of mental hygiene.

⁷ *Outline of Policy to be Submitted for Discussion at the Founding Meeting, February 19, 1909*; typed manuscript in files of National Committee for Mental Hygiene.

ANALYSIS OF DATA ON THE BASIS OF ADMINISTRATIVE
AUTHORITY

With such a diversity of administrative authorities it was difficult to find a basis for division among them that would facilitate the analysis of state-financed work in child psychiatry. Study of the material suggested, however, that very different opportunities and problems are encountered depending upon whether clinics are conducted by individual hospitals or by a department of the central government. Clinics under the two auspices differ not only in the geographical area to be served but in the likelihood of securing staff personnel specifically equipped for work with children, in policy-setting possibilities, and, perhaps, in the attitudes of the general public toward them. It seemed important, therefore, to put in one group the clinics conducted directly by departments of the state government, although it was known at the outset that many differences within the group would be found.

Looking over the data regarding the individual-hospital group, we soon discovered that the situation of a state hospital for mental diseases differs considerably from that of a psychopathic hospital. The latter is essentially an institution for the study of incipient mental disorders or for the observation of questionable cases. It has traditionally a preventive function, so that clinic work is taken for granted. In contrast, it is only with considerable effort that the state hospital enlarges its point of view to include examination and treatment of children, particularly those who cannot by any stretch of definition be considered in danger of psychosis. Again, psychopathic hospitals are usually located in large cities, where there are likely to be the supporting community resources, while state hospitals are usually located outside metropolitan centers and so can offer little clinic service except through staff units sent periodically into smaller towns and rural areas, where they are often handicapped by lack of social agencies.

It seemed, therefore, that our analysis of the clinics' work would be facilitated if psychopathic hospital clinics were considered apart from those maintained by other mental hospitals. The clinics of university hospitals and medical schools were found to be rather similar to the psychopathic hospital group in some respects and consequently were included with them. The remaining types of clinics (those conducted, for instance, by teacher-training institutions and by the psychology departments of universities) were excluded from the analysis as being either too ephemeral or too far removed from the purpose of our investigation.

As has been said before, our primary aim in studying state-financed clinics was to become sufficiently informed about their origins, aims, working methods, and achievements to be able to isolate and analyze some of their characteristic problems. On going over the available data about the three groups of clinics, we came to the conclusion that no single and rigid scheme of analysis could bring to light the various aspects of the clinics' work in such a way as to give the understanding of non-metropolitan problems that was desired. For example, there were some clinics or groups of clinics under a single administrative agency whose contribution could best be understood when they were described in their totality. Other clinics offered most fruitful suggestions when certain aspects of their work were selected for comparison. Again, in some instances the policies of the administrative bodies seemed of more importance for our study than the work of individual clinics; in others the reverse situation appeared. This contrast was particularly marked when the clinics of a given state hospital were compared with those of some department of a state government. For instance, the work of a state hospital clinic often appeared most interesting as illustrating what kind of service a hospital could offer under given circumstances. In contrast, in the state department situation it was usually the policies of

the department itself that were most important, for they tended to set the standard for the work that was done throughout the system. In addition, there was the fact that the clinics conducted by state hospitals so far outnumbered those in the other groups that exactly similar methods of analysis did not seem feasible. Accordingly, in the following chapters two different approaches to the data will be made. The state hospital clinics will be analyzed chiefly in cross-section, while with the others a case-study method of analysis will be used for the most part.

CHAPTER FIVE

Clinics Conducted by State Hospitals for Mental Disorders

THE great majority of state-financed psychiatric clinics for children (or for children and adults) are conducted by individual state hospitals for mental disorders.¹ Of the 373 clinics² listed in the 1935 directory compiled by the National Committee for Mental Hygiene, 281 were of that type. Within the category, however, there is great variation in organization, services, and manner of functioning. Some differences are of historical or of geographical origin; others apparently reflect differences in objectives, such as have been described in a previous chapter. No single cause operates, however, to divide the clinics into distinct types that can be separately considered. In surveying our data about the clinics in the light of the questions to be answered, we were therefore faced with an important methodological problem. To accomplish the purpose of the investigation as described in the preceding chapter it appeared, on the one hand, that some of the characteristics of state hospital clinics could be most profitably considered by means of case illustrations. For instance, it seemed that it would be more enlightening to describe typical ways in which clinic programs were initiated than to attempt to classify all the means that were used and to indicate

¹ In accordance with the custom of the U.S. Census Bureau, the following psychopathic hospitals, though officially belonging to the state hospital system, are not considered "state hospitals" and will be discussed later with other hospitals of more nearly their own type: University of Colorado State Psychopathic Hospital, University of Iowa State Psychopathic Hospital, University of Michigan State Psychopathic Hospital, Boston Psychopathic Hospital, Syracuse (N.Y.) Psychopathic Hospital, and New York State Psychiatric Institute and Hospital.

² A clinic is here (and throughout the book) defined in terms of its meeting place rather than its personnel; that is, if a hospital provides clinical service in more than one center it is counted as conducting more than one clinic even though the various centers may be served by the same staff members.

their frequency distribution. On the other hand, there were some questions that seemingly had to be answered in quantitative terms if they were to contribute much to our knowledge. In that category were such questions as size and composition of staff, frequency of clinic sessions, and the like. Accordingly we decided to use both methods: to answer some questions by means of typical examples and others by means of statistics. The latter method, of course, necessitated reference to a particular year, and 1935 had to be accepted, for it was then that the last census of clinics had been made. Questions that could be answered by the former method, however, did not suffer from that limitation; for, as we have said above, the validity of data about clinics' experiences is not greatly influenced by the time at which they occurred, since circumstances of time and place are themselves elements in the experiences.

NUMBER AND LOCATION OF STATE HOSPITAL CLINICS

In 1935 the list of states in which the mental hospitals conducted clinics to which children were admitted was as follows.

<i>State</i>	<i>Number of Hospitals</i>	<i>Number of Clinics</i>
California	3	5
Connecticut	1	1
Delaware	1	8
Illinois	6	14
Louisiana	1	1
Maine	1	1
Massachusetts	12	46
Michigan	4	19
New Hampshire	1	6
New Jersey	3	23
New York	19	92
Ohio	3	4
Oklahoma	3	3
Pennsylvania	6	44
Rhode Island	1	2
South Carolina	1	10
Washington	1	1
Wisconsin	1	1
Total	68	281

The clinics of five state schools for the feebleminded (in Massachusetts and in New York) are included here and in the rest of this chapter, since they gave psychiatric service similar to that of many state hospitals. In addition, Maryland had two clinics staffed by state hospital members but the clinics were technically under the direction of the State Board of Health. This list shows that eighty per cent of the state hospital clinics were located in five states—New York, Massachusetts, Pennsylvania, New Jersey, and Michigan—with Delaware, Illinois, and South Carolina containing the majority of the rest.

There were several kinds of clinic service in hospitals. The simplest was a clinic held at the state hospital. This was the situation in the following institutions:

- California—Stockton State Hospital
- Illinois—Alton State Hospital, Chicago State Hospital
- Louisiana—Central Louisiana State Hospital
- Maine—Bangor State Hospital
- Massachusetts—Belchertown, Waverly, and Wrentham
State Schools for the Feebleminded
- New York—Letchworth Village (school for the feebleminded)
- Oklahoma—Northern and Eastern State Hospitals
- Washington—Eastern State Hospital

The next type of clinic held its sessions off the hospital grounds:

- Connecticut—Middletown State Hospital
- Massachusetts—Worcester State Hospital
- Ohio—Longview and Toledo State Hospitals
- Oklahoma—Central State Hospital
- Wisconsin—Wisconsin State Hospital

It had generally been found that work was handicapped by hospital surroundings and so the clinics were moved to such quarters as general hospitals, social agencies, or separate offices of their own in town. The Worcester clinic differed

from the rest in this group in that it was a full-time, stationary clinic with a building and staff of its own. Most of the other clinics met once or twice a month, and their staffs consisted of individuals who gave most of their time to hospital work.

The third type was the clinic conducted by a staff that went to several centers at regular intervals. In the list of such clinics that follows, the towns served, as well as the hospitals conducting the clinics, are noted:

- California: Norwalk State Hospital: Los Angeles, Orange
 Patton State Hospital: Riverside, San Bernadino
- Delaware: Delaware State Hospital: Dover, Farnhurst,
 Georgetown, Laurel, Wilmington (4)
- Illinois: Anna State Hospital: Anna, Benton
 East Moline State Hospital: Dixon, East Moline, Freeport,
 Galesburg, Kewanee, Moline
 Jacksonville State Hospital: Jacksonville, Springfield
 Kankakee State Hospital: Danville, Joliet
- Massachusetts: Danvers State Hospital: Beverly, Haverhill,
 Lawrence, Lynn (2), Melrose, Newburyport, Salem
 Foxboro State Hospital: Boston, Brockton
 Gardner State Hospital: Fitchburg (2), Gardner, Orange
 Grafton State Hospital: Belmont, Concord, Leominster,
 Lexington, Natick, North Grafton (2)
 Medfield State Hospital: Norwood, Quincy (2)
 Northampton State Hospital: Greenfield, Holyoke, North
 Adams, Northampton (2), Pittsfield, Springfield (2)
 Taunton State Hospital: Attleboro, Fall River, New Bedford,
 Taunton
 Westboro State Hospital: Boston, Framingham (2), Lowell,
 Waltham, Westboro
- Michigan: Kalamazoo State Hospital: Grand Rapids, Kalamazoo,
 Lansing, St. Joseph
 Newberry State Hospital: Escanaba, Hancock, Ishpeming,
 Marquette, Negaunee, Sault Ste. Marie
 Pontiac State Hospital: Mt. Clemens, Owosso, Pontiac,
 Port Huron

- Traverse City State Hospital: Bay City, Midland, Muskegon, Saginaw, Traverse City
 New Hampshire: New Hampshire State Hospital: Concord, Dover, Manchester (2), Nashua, Portsmouth
 New Jersey: Marlboro State Hospital: Elizabeth, Lakewood, Neptune, New Brunswick, New Lisbon, Plainfield, Red Bank
 Trenton State Hospital: Belvidere, Camden, Phillipsburg, Somerville, Trenton (3)
 New York: Binghamton State Hospital: Binghamton (2), Cortland, Elmira, Oneonta
 Buffalo State Hospital: Buffalo (2), Lockport, Niagara Falls, North Tonawanda
 Central Islip State Hospital: Lindenhurst, New York (2), Patchogue
 Creedmore State Hospital: New York
 Gowanda State Hospital: Dunkirk, Jamestown, Olean, Salamanca
 Harlem Valley State Hospital: Mt. Kisco, New York (2), White Plains, Wingdale, Yonkers, Yorktown Heights
 Hudson River State Hospital: Kingston, Newburgh, Poughkeepsie
 Kings Park State Hospital: Floral Park, Huntington, Mineola, Oyster Bay, Riverhead
 Letchworth Village: Thiells
 Manhattan State Hospital: New York (2)
 Marcy State Hospital: Fulton, Glens Falls, Oneida (2), Oswego, Rome, Wampsville
 Middletown State Hospital: Kingston, Middletown (2), Monticello, Newburgh, New York, Port Jervis
 Newark State School: Newark, Lyons
 Pilgrim State Hospital: Baldwin, Bay Shore, Freeport, Oceanside, Rockville Center, Westhampton Beach
 Rochester State Hospital: Batavia, Rochester
 Rockland State Hospital: Congers, Hillburn, Monsey, Mt. Vernon, Nanuet, Nyack, Pearl River, Piermont, Ossining, Sloatsburg, Sparkill, Spring Valley, Suffern, Tallman, Tappan, Tarrytown, Tompkins Cove
 St. Lawrence State Hospital: Carthage, Ogdensburg, Watertown

State Hospital Clinics

- Utica State Hospital: Amsterdam, Gloversville, Johnstown, Schenectady, Utica
- Willard State Hospital: Auburn, Corning, Geneva, Hornell, Ithaca, Willard
- Ohio: Massillon State Hospital: Canton, Massillon
- Pennsylvania: Allentown State Hospital: Allentown (2), Bethlehem (2), Easton, Palmerton
- Danville State Hospital: Bloomsburg, Danville, Hazelton, Lock Haven, Mt. Carmel, Shamokin, Sunbury, Wilkes-Barre, Williamsport (2)
- Harrisburg State Hospital: Chambersburg, Harrisburg
- Norristown State Hospital: Bristol, Chester, Coatesville, Doylestown, Jenkintown, Norristown, West Chester
- Torrance State Hospital: Greenburg, Hollidaysburg, Indiana, Somerset, Uniontown, Washington, Waynesburg, Windber
- Warren State Hospital: Bradford, Clearfield, Coudersport, Dubois, Erie (2), Kane, Meadville, Phillipsburg, Ridgway, Warren
- Rhode Island: Rhode Island State Hospital: Westerly, Woonsocket
- South Carolina: South Carolina State Hospital: Anderson, Charleston (3), Columbia, Florence, Greenville, Orangeburg, Rock Hill, Spartanburg

ORIGINS OF CLINICS UNDER STATE HOSPITAL AUSPICES

The general historical trend with respect to the origin of psychiatric service for children has been described in a previous chapter. There it was shown that the movement was from outpatient services for paroled patients and later for potential patients, such as neurotic and pre-psychotic adults, to various types of service for children. But this development was not repeated anew in each hospital, nor were the forces and motives back of the movement toward the provision of psychiatric services for children identical in each place. Accordingly, a consideration of the variety of ways in which

the clinics came into being throws light on other diversities.

It has been shown above that in 1935 there were thirty states in which the mental hospitals maintained no extramural clinics to which children are admitted. Since these states contain seventy-three mental hospitals financed by public funds (nearly half of the total in the United States), an appropriate starting point for an analysis of state hospital clinics would seem to be the opinion of a superintendent of a state hospital to whose clinics children are only rarely admitted. This superintendent said that in his judgment a hospital's first duty was to its inpatients and that an extensive community program was not warranted unless a staff specially equipped for such work was provided. He deplored the tendency to "oversell" mental hygiene and said he believed that clinic work carried on by a staff of ward psychiatrists not only handicapped the hospital's normal work but was of little value to the outpatients as well.

This sort of opinion is doubtless held by other state hospital superintendents. Some information on this point is to be found in the replies of state hospital superintendents to letters sent to them by our investigators in 1933. Some few gave opinions of substantially this type. Other superintendents, perhaps less frank, merely stated that their hospitals maintained no clinics, while a considerable proportion expressed regret that they did not have such facilities. The usual reason given for the lack was that both staffs and appropriations were too small—inadequate even for effective inpatient work. Some superintendents who expressed this opinion said they hoped their hospitals could some day start clinic work. Others said that the population of their states was too small and the distances too great to warrant such a program, while a few replied that adequate clinics in nearby centers precluded the need for their offering such services.

Intimations of an approach to work with children were offered by a group of superintendents who reported that the hospital psychiatrists did examine a few children each year on referral from private physicians, visiting nurses, teachers, social workers, and the like. Replies of that type were received from some hospitals and schools for the feebleminded in Alabama, Indiana, Kansas, Maryland, Mississippi, Missouri, and Nebraska. In Illinois the state hospitals admit children as patients to their parole-clinic sessions only on written request of a physician. The next step in the typical developmental pattern is to reserve definite hours for the examination of children and so to separate preventive from parole work.

It seems, therefore, that some programs owed their origin chiefly to outside pressure. Whether the initiative in establishing clinics came from within the hospital or from outside is not a distinction that can be made in absolute terms, since frequently the stimulation seems to have been mutual. In so far as it is a valid distinction, however, it is of interest in showing the variety of persons and organizations seeking psychiatric assistance for children. These, as revealed by our survey of clinics, have been physicians, schools, courts, social agencies, and various state departments.

An interesting and probably unique example of a clinic representing a joint request from physicians and social agencies was the Mental Health Clinic in the Erie (Pennsylvania) General Dispensary, established in 1923 and discontinued for financial reasons in 1932. The dispensary itself was somewhat unusual, having been set up at the initiative of two family welfare agencies and backed by the county medical society. The governing board of the dispensary contained about fifteen medical specialists, the staff consisted of two young physicians and a medical social worker, and the project was financed by the Community Chest. The dispensary board requested the Warren State Hospital to provide psychiatric

service, and clinics of this type were held two half-days a month, the dispensary providing a social worker who investigated applications, arranged appointments, and did the follow-up work. During the nine years that the clinic was in operation, about four hundred psychiatric patients were examined, a fourth of them being children.

The clinic conducted by the Medfield (Massachusetts) State Hospital in Quincy was found to be an example of psychiatric services given at the request of a health department. In this city the health officer was interested in all types of clinic work and had already secured a weekly habit clinic from the state's division of mental hygiene³ when he asked the state hospital for one to serve older children and adults. Much of the work of this clinic was done through the schools, half of its first year's cases coming from that source. Private physicians referred few children to the clinic but apparently were not antagonistic, no doubt partly because the clinic included a physician as well as a psychiatrist from the hospital on its staff and referred all children with physical disabilities to their family doctors.

Erie, Pennsylvania, provided an example of a clinic initiated at the request of the public schools. The schools of that city were particularly interested in the education of intellectually retarded children, and their desire for psychiatric assistance grew out of their recognition that some children could not be trained even in special classes. A local psychiatrist gave them consultation service for some time. When he left, the schools' request to the State Bureau of Mental Health for aid was referred to the Warren State Hospital. A psychiatrist giving, eventually, two days a month to the work was assigned by the hospital to the schools, the psychological and case work services being provided by the schools and the whole service integrated with the special class work under the

³ See Chapter VIII for a description of the habit clinics.

Child Study Department. During the ten-year period, 1922 (when the clinic was established) to 1932, about 600 children were examined, approximately half of them being feeble-minded.⁴

In a few cities state hospitals were found to have established clinics—or at least to give psychiatric service—in the juvenile courts as a result of a direct request of the court itself. Work with and through the courts is particularly characteristic of many of the clinics conducted by the Michigan state hospitals but it is not clear that the original impetus to such service originated with them. In Massachusetts, however, at least two examples of service to courts in which the original impetus came clearly from the courts themselves were found. In Chelsea, for instance, the judge of the juvenile court came to an appreciation of the value of psychiatry through contacts with the State Department of Mental Diseases, and at his request the Danvers State Hospital began in 1930 to provide the court with a psychiatrist for one day a week. The same arrangement had been in effect in the Springfield District Court since 1922, when the judge asked for the help of a psychiatrist from the Northampton State Hospital, who had been working with outpatients of the hospital for at least ten years. To both of these clinics the hospitals supplied only a psychiatrist, the psychological and social service work being carried by the courts' regular staff. In Springfield the probation officers made home investigations as requested by the psychiatrist and attempted to carry out her recommendations. By this procedure a considerable number of children were said to have been spared a court appearance.

When clinics or psychiatric facilities are provided at the request of schools and courts the tendency, naturally enough, is to restrict intake to their charges and to the particular inter-

⁴ Ira A. Darling, "Child Guidance Clinics as Conducted in the Public Schools of Erie, Pennsylvania," *Pennsylvania Medical Journal*, Vol. XXXIII (1929), p. 58-60.

ests of the authorities in question. With courts the restriction follows from the nature of the situation, and although the provision of psychiatric examinations does sometimes tend to reduce court hearings, the fact that the children must be apprehended or complained about before they come to the attention of the psychiatrist puts a real limitation on psychiatric work. The schools are not so limited by necessity. The experience of the hospitals with school-initiated clinics has been, however, that help is wanted chiefly with the feebleminded and with the children who manifest gross conduct disorders. The schools usually want advice as to what can be done for the children within the school situation or how they can get rid of them entirely, and few of them seem to desire a case work type of treatment. Our survey of the clinics gave evidence that this arrangement was generally mutually satisfactory—the schools and courts feeling helped by the psychiatrists' recommendations, and the staffs of the clinics being interested in the types of cases that were brought before them.

In services that were initiated at the request of social agencies the possibility of disagreement in aims seemed more likely, since the trend in case work is toward a treatment type of psychiatry. Examples of clinics established at the request of social agencies were found in Easton, Pennsylvania, and Lynn, Massachusetts. The clinic in the former city was established in 1915, following a request from the Social Service League. It was located in the state hospital at first and was later moved to an office in a general hospital, where paroled patients, adults suffering from incipient mental disease, and children "suspected of being in the exceptional class" were examined. The superintendent of the state hospital became interested in the Massachusetts program of examining all children retarded in school and seemed to think of the clinic's service to children chiefly in psychometric and organic terms.

The original staff was later expanded to include a psychologist and trained psychiatric social workers but much of the clinic procedure (the lack of privacy in interviewing, verbal reports to referring agents, lack of treatment following study) gave evidence that the clinic saw its function largely in terms of diagnosis of children who were not amenable to individual therapy. The social agencies, on the other hand, became increasingly desirous of psychiatric service that would help them in their work with less handicapped children, and for some years they have been trying to establish a child guidance clinic of the treatment type.

The clinic operated by Danvers (Massachusetts) State Hospital in Lynn is an interesting example of growth in community understanding and of the adaptation of the clinic's facilities to expressed needs. It was first set up in 1924, simultaneously with the establishment of a habit clinic by the state, and served both adults and children. The two services worked side by side for two years, when the habit clinic was merged with the hospital's clinic. The new clinic had been in operation only a short time when it was closed because of lack of interest on the part of the local social agencies. In 1928 it was revived at the express request of the Lynn Case Conference, the local council of social agencies, and arrangements were made for giving one half day's service a week (later expanded to one and a half) to children exclusively. Headquarters were first established in a school building and later moved to a nursing and child-placing agency's building. The staff in 1933 consisted of a psychiatrist who gave full time to clinic work, a psychologist, two psychiatric social workers, three students in social work, and a speech teacher. Children were seen by appointment only, the referrals coming almost wholly from the schools and the social agencies. The clinic had enthusiastic backing, and its social workers became members of the local Case Conference. Very few feebleminded

children were referred to the clinic, a high proportion of the patients received more than diagnostic service, and the clinic worked closely with the referring social agencies. The success of this clinic among agencies that were probably fairly sophisticated along psychiatric lines seemed again attributable to the fact that the clinic's service and the referring agents' desires were in close agreement with each other.

Clinics set up at the request of particular groups in the community thus have some characteristic problems growing out of that relationship. Somewhat similar ones arise in clinics that are initiated by hospitals to serve particular groups. An interesting example of this situation was seen in the Iowa Psychopathic Hospital clinics,⁵ which under Dr. Orton's leadership concentrated their attention on reading disability cases to such an extent that their other services remained relatively undeveloped.

Another example of a clinic set up to meet the needs of a particular group of children was found in the Grafton (Massachusetts) State Hospital. Massachusetts has a "school clinic" program, under which all children more than three years retarded in school are examined by psychiatrists and psychologists sent out from the state hospitals. A psychiatrist added to the Grafton staff in 1928 for school-clinic work became interested in the children found to be not seriously defective mentally. Of the five hundred children examined in 1929, for instance, over seventy per cent had an intelligence quotient above 75, and fifteen per cent were in the normal group. Through the psychiatrist's interest in securing some treatment for this group that were not eligible or suitable for the special classes provided by law for the feebleminded, "adjustment clinics" were established. Children with any type of personality or behavior difficulty were accepted for treatment. The clinics differed from the usual traveling clinics of state

⁵ Described in Chapter VII.

hospitals, however, in that they were held in the schools, received their patients wholly through the schools, and carried on practically all their work in and through that environment. The staff consisted of a psychiatrist and a psychologist, who supervised the school nurses in compiling data regarding the children referred. The psychiatrist carried the bulk of treatment, dealing directly with the children in her office in the school. The problems—as well as the advantages—arising in these clinics seemed to grow largely out of this school affiliation. Since referrals came almost wholly from teachers, the psychiatrist had the task of educating them in mental hygiene. Parents' attitudes toward clinic referral were apparently largely disregarded, since practically all the work with the children was carried on within the schools. Other contacts outside the school were also less frequent than in the usual child guidance clinic. Most of these divergencies from accepted practice did not seem to be necessary limitations in a clinic conducted specifically for school children but, on the other hand, there was little evidence that they were creating difficulties.

INITIATING CLINIC SERVICE

Although some hospitals organized their clinics in response to specific requests from the outside and others set them up because of a specific need which they saw in the course of their usual work, the majority of hospitals had less immediate reasons for embarking upon a program that included service to children. Their usual objectives were those that have been previously described: to diminish the number of institutional admissions, either directly or through preventive measures, and to serve the surrounding community in the wider field of mental health.

When the decision to enter upon a community program originates with the hospital authorities and is not the result of

mutual stimulation between the hospitals and other agencies in the community, the problem of introducing the clinics to the community arises. As has previously been indicated, understanding and cooperation on the part of various sections of the professional and lay public are considered prime requisites for the success of child guidance clinics, not only from the point of view of referrals (for doubtless some individuals would come to clinics under any auspices) but especially because of the need for supplementation of the clinic's work. This latter aspect of community relationships is of special importance to traveling clinics, since they can be held only infrequently and usually depend on local agents for carrying much of the recommended treatment.

Within the common plan of personal discussions with prominent people, lectures to the general or the professional public, and announcements of scheduled clinic meetings, there was found to be considerable variation in the way in which a clinic was introduced into a community. One difference appeared in the groups with which particularly favorable contacts were sought. Some hospital superintendents thought that alliance with the local medical profession was especially important; others worked through the courts or the schools, while others considered a close tie with the local social agencies the best means of furthering their objectives. Concentration on one or another of these groups did not imply that the cooperation of the others was judged unimportant, but in many clinics a definite tendency to work more closely with one than with another was found.

When the superintendent of the Kalamazoo (Michigan) State Hospital, for instance, began the organization of community clinics in 1916, his chief efforts were directed toward securing cooperation from the juvenile court. He first won the interest of the judge of the Grand Rapids Probate Court (which includes the juvenile court) in his plan and set up a

clinic in that county. The County Commissioners agreed to pay the traveling and maintenance expenses of the clinic's staff. This plan was duplicated later in other counties and taken over by some of the other hospitals in the state. The relationship between court and clinic became so close in some Michigan communities that appointments for examination in the clinics were made through the Probate Court and reports of findings were made to the judge after each clinic session. This relationship appeared to have the consequences that would be expected. Referrals to the clinic came largely from the court, and feebleminded and neurological cases predominated. Court workers and others without case work training found the recommendations of the clinics useful, but there was some tendency among the social agencies to desire more specific help with problems of family relationships than the clinics, oriented toward psychometric and physiological explanations, were prepared to offer.

An example of particularly cordial relationships with the medical profession was found in the clinics of the Taunton (Massachusetts) State Hospital, where the superintendent pursued a definite policy of seeking a tie-up with local boards of health. He found that by this method conflicts with the medical profession about free clinics and with political, religious, and social groups about certain other questions were avoided. The Foxboro (Massachusetts) State Hospital also seemed to have achieved unusually good relationship with the local physicians, partly through the fact that the director of the clinic served as neurologist on the staff of the local general hospital. Other examples of the relationships of clinics with local physicians were noted in various centers. The Warren (Pennsylvania) State Hospital, for instance, had a policy of not opening a clinic except at the request of the local medical society and the offer of financial support (travel and maintenance expenses for the staff) from the

community. The Northern New Jersey Mental Hygiene Clinics provided in one community an example of continuous difficulties because of the opposition of the county medical society, and in another an example of particularly favorable progress, traced in part to the good relationship which the clinic director established with the medical group and his custom of presenting cases at the local hospital's annual "demonstration clinic."

For the most part, however, the attitude of local physicians to state hospital clinics was reported as neutral, uninterested, or uninformed rather than either antagonistic or definitely favorable. The effect of such an attitude on the work of the clinics seemed to be reflected chiefly in the scarcity of referrals from private medical sources. While not actively a hindrance to the clinics' work, this scarcity of private referrals was sometimes considered a handicap, in that the clinics were deprived of the types of cases in which good results were generally to be expected. Such an attitude on the part of local physicians also tended to be professionally dissatisfying to the psychiatrists on the clinic staffs, since many of them felt that much could be accomplished through mutual consultation about cases.

From the point of view of putting the clinics' recommendations into effect, however, cooperation from schools and health and social agencies seemed more important. In launching a program in a community, then, particular attention was usually paid to building up relationships with these sources of supply. The superintendent of the Agnew (California) State Hospital, for instance, said that while he thought the initiative in starting a clinic should come from the hospital, the schools and health agencies were the best source of patients and must, therefore, be kept continually stimulated. The failure of one clinic under his hospital was attributed to the failure of the staff to keep alive the interest of the visit-

ing nurses' association. The superintendent of the Danville (Pennsylvania) State Hospital was even more emphatic. He said that clinics can be successful only in so far as the communities appreciate what they are for, how they function, and what they may be expected to accomplish. A persistent, intensive, systematic educational program he considered the backbone of an efficient extra-hospital service, and his hospital sponsored a wide variety of educational activities.⁶

An example of unusually careful preparation for the introduction of a clinic appeared in the Sussex County clinic of the Northern New Jersey Mental Hygiene Clinics. In contrast to the usual method of having the hospital psychiatrists make the preliminary arrangements, much of the preparation here was left to the psychiatric social worker who was assigned to the unit. She spent much time in becoming acquainted with the various social agencies in the county, regularly attended the meetings of the County Welfare League and the local health organizations, gave many talks on mental hygiene subjects, and in all her contacts took special care to explain clearly the purpose and functions of the proposed clinic. The clinic started, then, with more knowledge of the community's desires, resources, and limitations than is usual, and its later educational efforts were directed toward fostering more adequate facilities for meeting children's needs.

The use of the local mental hygiene society for initiating a clinic program in a community was found to be common in Massachusetts. Under the guidance of the state society local groups would interview prominent individuals, hold conferences, and sponsor talks on mental hygiene. When enough backing was secured the local state hospital would be approached and another period of consultation and interpretation—this time by members of the hospital staff—would

⁶ See J. Allen Jackson and Horace V. Pike, "Eight Years of Clinical and Educational Work in the Community," *American Journal of Psychiatry*, Vol. IX (1929), pp. 237 f.

begin. Little could be learned as to the results of this method of promoting clinics. One superintendent implied that he thought it good, since he said that clinics were most successful when opened at the request of the community, and another expressed doubts about the method by saying that mental hygiene is frequently "oversold." One superintendent tried to counter this danger by emphasizing in his talks the limitations as well as the advantages of mental hygiene clinics.

A contrast to these various methods of preparing the way appeared in the statements and practices of a few hospital superintendents who were opposed to all elaborate preparation. To such men it seemed that a notice in the newspaper and announcements of the proposed clinic schedule sent to the various professional groups were enough. The work of the clinic should speak for itself, and its recommendations could be made directly to the persons who brought the patients to it. In general it was found that the patients of such clinics were grossly handicapped individuals and that the clinics' services did not go much beyond diagnosis and recommendations for placement.

Closely allied to the problems of initiating a program are those which belong to what is called education. These activities have various objectives and cut across the whole of a clinic's thinking and practice. Some of them appear to be aimed chiefly at sustaining interest in the clinic and enlarging, as it were, its source of supply. Many of the general "talks in the community"—to church groups, to parent-teacher associations, to lodges and clubs of many varieties—are of such a nature. Staff members of most clinics reported doing a considerable amount of this work. Some of them were enthusiastic about it. They regarded it as a means of teaching mental hygiene rather than of promoting the clinic, and believed that this was an important function of the clinic. Others had less conviction about its value but felt that they were almost

forced to do it by the pressure of public interest. Some went so far as to say that general talks were a waste of time, that few people who attended were open to that type of instruction, and that the patients referred to the clinic as a result of such lectures tended to be untreatable types. Others, in contrast, reported that they considered this one of the most important aspects of a clinic's work—that tolerance and understanding of emotionally handicapped individuals were promoted by this method, and that the clinic received some of its most interesting cases from such sources. No conclusions could be drawn from these brief and divergent comments, but there was some suggestion that the results varied with the personality of the speaker and the content of his addresses.

Other educational activities of clinics with the lay public have a less direct objective. They are motivated by the fact that clinics cannot work in a vacuum but must have favorable conditions for their patients in the form of medical, educational, recreational, and other social-service resources. All of these require community backing. The task of remodeling the community cannot be assumed by a clinic, of course—especially one that travels from place to place—but many clinics stated that their work was handicapped by such lacks, and some few had made efforts to interpret their needs to the general public.

More usual was the practice of offering mental hygiene lectures to various professional groups. The aim in some of this work seemed to be general: for instance, the lectures and demonstrations to normal school, college and theological students. Other efforts were more directly aimed at improving the facilities with which the clinics worked or at making some of their work unnecessary. As such might be classified the lectures to nurses and teachers, the (very occasional) work with pediatricians and others in the medical profession, the institutes and seminars led by members of clinic staffs. More

immediate was the rather widespread practice of inviting teachers, nurses, social workers, and physicians to staff conferences in regard to specific cases, where the points of view of the clinic and the outside workers might be pooled. Many clinics complained that the histories submitted by referral sources were inadequate; others used instruction in the requirements of a written history as a means of promoting inter-agency relationships. In some few communities mutual cooperation and understanding among social agencies was promoted by the attendance of the clinic social workers at the local social workers' discussion club meetings, and one hospital (Utica, New York) had recently found it advantageous to district its social workers and have them live in their district centers. By and large, good results were said to follow from such educational activities, one drawback being, however, that the demands on the clinics' time—both for lectures and conferences and for increased psychiatric and case work assistance—tended to become too great.

THE PATIENTS OF STATE HOSPITAL CLINICS

The number of patients served

Since state hospital clinics range from those primarily set up for patients on parole to those which attempt to meet the general mental hygiene needs of the community, there is considerable diversity among the types of patients. No exact count was available to show how many clinics served both paroled patients and other adults and children as well, but the practice is known to be very common.

The 1935 census did provide some information, however, with regard to the proportion of children among the clinics' patients. Unfortunately, no figures were available for Illinois and South Carolina,⁷ and for several hospitals in other states.

⁷ Illinois hospital clinics had very few child patients but those in South Carolina probably examined a considerable number.

Altogether, fifty-nine of the sixty-eight state hospitals providing clinics to which children are admitted reported the age of their patients, as did 172 of the 281 clinics. Twenty-eight per cent of these clinics had no adults among their new cases in 1935, and ten per cent had no child patients. The others ranged between these extremes, the tendency being to examine a larger proportion of children than adults. The figures are given in Table II.

TABLE II

Distribution of state hospital clinics by states according to proportion of children among patients in 1935

	Number of Clinics with Given Percentage of Child Patients							Not stated	Total
	None	1-19	20-39	40-59	60-79	80-99	100		
California	—	1	—	3	—	1	—	—	5
Connecticut	—	—	—	—	1	—	—	—	1
Delaware	—	—	—	—	8*	—	—	—	8
Illinois	—	—	—	—	—	—	—	14	14
Louisiana	—	1	—	—	—	—	—	—	1
Maine	—	—	—	—	—	1	—	—	1
Massachusetts	12	2	1	1	5*	14	10	1	46
Michigan	—	—	4*	5*	4*	—	—	6	19
New Hampshire	2	—	2	—	—	1	—	1	6
New Jersey	—	—	—	9*	—	—	—	14	23
New York	4*	19*	12*	5*	9*	4*	31	8	92
Ohio	—	2	—	1	—	1	—	—	4
Oklahoma	—	—	1	—	—	—	—	2	3
Pennsylvania	—	—	2	10	9	14	7	2	44
Rhode Island	—	—	—	—	1	1	—	—	2
South Carolina	—	—	—	—	—	—	—	10	10
Washington	1	—	1	—	—	—	—	—	2
Total	19	25	23	34	37	37	48	58	281

* Refers to group of clinics under one hospital.

The actual number of children examined also varied widely, depending in part, of course, upon the frequency and length of the clinic sessions and the size of the communities served. The figures are important as indication of the extent to which state hospital clinics are meeting the need for psychiatric service for children—impossible as it is to say how

extensive that need may be. Table III gives the figures by hospitals, since data for the individual clinics of several states were lacking.

Containing data for fifty-nine of the sixty-eight hospitals, Table III shows that twenty-one hospitals examined less than fifty new child patients in 1935. These hospitals conducted seventy-five clinics, so the figure indicates that more than a fourth of the state hospital clinics served very small numbers of children. On the other hand, there was a group of clinics in which large numbers of children were studied.

Distinct differences among the states were found. In almost half of the eighteen states in which the mental hospitals conducted clinics so few children were examined annually as to make the service appear to be almost negligible. Among the states with many clinics the contrast between Massachusetts and Pennsylvania, on the one hand, and New York, on the other, was striking. Fourteen of the nineteen New York hospitals examined less than fifty children in their clinics in 1935, while all of the hospitals in the other two states had more than that number of patients. Each of these states, as a later chapter will show, had a series of clinics conducted by a central state department as well, one of whose objectives was the stimulation of children's clinics in the state hospitals.

Regardless of size of community served and variation in estimates of need among children for psychiatric help, it seems difficult to conclude anything other than that the state hospital programs must leave many children uncared for. To take the most striking example, twelve of the nineteen New York state hospitals examined an average of less than ten new child patients per community in 1935. Then, too, three of the clinics examining large numbers of children were located in schools for the feebleminded, and doubtless most of their patients were of that type. It is noteworthy that the other clinics with a high intake were not held in very large

TABLE III
Distribution of hospitals according to number of new child patients examined in clinics in 1935

		Number of Clinics with Given Number of New Child Patients*											
		<i>Less than</i>									<i>500 & over</i>	<i>Not stated</i>	<i>Total</i>
		<i>10</i>	<i>10-24</i>	<i>25-49</i>	<i>50-99</i>	<i>100-199</i>	<i>200-299</i>	<i>300-399</i>	<i>400-499</i>	<i>500 & over</i>	<i>Not stated</i>	<i>Total</i>	
	California	—	—	1	1	1	—	—	—	—	—	3	
	Connecticut	1	—	—	—	—	—	—	—	—	—	1	
	Delaware	—	—	—	—	—	—	—	—	—	1	1	
	Illinois	—	—	—	—	—	—	—	—	—	6†	6	
	Louisiana	—	—	1	—	—	—	—	—	—	—	1	
	Maine	—	—	1	—	—	—	—	—	—	—	1	
	Massachusetts	—	—	—	2	6	2	1	—	1	—	12	
	Michigan	—	—	—	1	1	—	1	—	—	1	4	
	New Hampshire	—	—	—	—	1	—	—	—	—	—	1	
	New Jersey	—	—	—	—	—	—	—	1	—	2	3	
104	New York	7	3	4	1	1	—	—	1	—	2	19	
	Ohio	—	1	1	—	1	—	—	—	—	—	3	
	Oklahoma	—	—	—	1	—	—	—	—	—	2	3	
	Pennsylvania	—	—	—	1	1	2	1	1	—	—	6	
	Rhode Island	—	—	—	1	—	—	—	—	—	—	1	
	South Carolina	—	—	—	—	—	—	—	—	—	1	1	
	Washington	—	—	—	—	—	—	—	—	—	1†	1	
	Wisconsin	—	1	—	—	—	—	—	—	—	—	1	
	Total	8	5	8	8	12	4	3	3	1	16	68	

* The hospitals which examined over 200 new patients in 1935 were:

Massachusetts: Grafton, 7 clinics; Worcester, 1 clinic; Waverly and Wrentham schools for feeble-minded, 1 clinic each.

Michigan: Traverse City, 4 clinics.

Pennsylvania: Danville, 10 clinics; Norristown, 7 clinics; Torrance, 8 clinics; Warren, 11 clinics.

New Jersey: Greystone Park, 9 clinics.

New York: Kings Park, 5 clinics.

† It is known that very few children were examined by these clinics.

cities. The conclusion cannot be escaped that an adequate program for the psychiatric examination—not to say, care—of children cannot be expected of state hospitals, at least with their present staffs and funds.

Types of patients

Another question of interest is what types of children appear most frequently among the patients of state hospital clinics. Although exact figures on this point are not available, our 1932 survey showed that many of the patients of most clinics, especially those that combined parole and other outpatient work, were children who were suspected of being feeble-minded or of suffering from some neurological disability. But cases of these types were not limited to such clinics. In the absence of detailed figures a few examples must suffice to make this point. The Danville (Pennsylvania) State Hospital, for instance, was one of the three hospitals that examined over four hundred children in 1935. In its Williamsport clinic it was noted in 1932 that not more than twenty of the seventy new cases were of the child guidance type—that is, children whose behavior difficulties seemed attributable to factors other than mental deficiency or neurological conditions. In its Wilkes-Barre clinic the comparable figures were forty-nine out of three hundred and eight children examined. Thirty per cent of the child patients in the latter clinic were recommended for intramural care.⁸ In Stockton, California, the psychiatrist in charge of the clinics in 1932 said that mental defectives predominated among the children referred to their clinics, although there were a few children of unusually high intelligence among them. In the clinics conducted by the Michigan hospitals much the same situation was found. As has already been noted, many of these latter clinics had close

⁸ *Mental Health Bulletin*, Pennsylvania Department of Welfare, Vol. X (October 1932).

connections with the juvenile courts, and the social agencies and courts used them largely for securing intelligence ratings and mental diagnoses for children for whom they were considering placement.

In Massachusetts, on the other hand, a diversity in practice was found. The Westboro State Hospital, for instance, combined parole and outpatient work, made no formal announcements of service, and received chiefly children suffering from gross feeble-mindedness or organic conditions. It was the practice of this hospital to refer typical child guidance cases to other clinics or social agencies. The Northampton State Hospital, on the other hand, tended to specialize its services. It had a clinic primarily for court cases in Springfield, and in Greenfield gave much of its time to giving psychological tests to children referred to it by the Society for the Prevention of Cruelty to Children. The Grafton Hospital, as previously described, provided "adjustment clinics" in the public schools, in which children of all types, but chiefly those of low intelligence, were accepted as patients. In contrast, the Medfield and Danvers hospitals conducted general community clinics, to which referrals tended to be of the child guidance type, and the clinic of the Worcester Hospital was strictly devoted to child guidance work.

Some hospital superintendents said it was their policy, as directors of state institutions, to accept whatever patients were referred to the clinics, and in some states this policy appeared to be a statutory necessity. The Delaware law, for instance, explicitly requires that the clinics examine feeble-minded children on request, as well as the inmates of state and county institutions, persons charged with any offense, and the clients of social agencies, hospitals, and institutions for the feeble-minded. By reason of such policies the New Jersey clinics also receive a widely mixed group of patients, even the treatment clinics of the Greystone Park (New Jersey) State Hos-

pital accepting as patients persons referred only for mental testing.

Such practices appeared to have two results. On the one hand, inclusion of feeble-minded and neurological cases frequently crowded a clinic's calendar and discouraged the referral of patients whose problems seemed to require immediate attention. On the other hand, the clinics acquired the reputation of being a place of last resort, their mental hospital aspects being reinforced for the layman by the character of their intake.

By and large, then, our investigators found in 1932 that the state hospital clinics gave service chiefly to children who were handicapped by neurological disabilities or low intelligence and that only the Worcester Child Guidance Clinic and some of the clinics conducted by the Danvers (Massachusetts) State Hospital restricted their intake to the child guidance type of case. If this were the whole story the problem would be relatively simple, and the clinics and their work could be judged purely in the light of the needs of these types of patients. Several factors, however, introduce complications. It has already been noted that there were clinics whose clientèle presented a less uniform character. More important is the fact that diagnoses may vary with predilections of the examiners, as well as with the disabilities of the patients. When the director of one clinic reports that psychotic children are extremely rare and that of another lists dementia praecox and hysteria fairly frequently among his diagnoses, one cannot escape the suspicion that the preconceptions of the mental hospital exert their influence even in clinical work with children. Diagnoses usually carry implications as to treatment. Even when they serve merely as labels they may handicap the child in his relationship with relatives, teachers, and friends. On the other hand, clinics that conceive of their function largely in terms of mental deficiency and mental or

neurological disease may pass by those children whose difficulties do not lie in these spheres and, by their very lack of diagnosis, confirm the referral agents in their suspicion that the children are deliberately incorrigible. It is not enough, then, to say that the clinics tend to limit their intake to particular types of children. One must inquire further as to what services they offer and what preparation the staff members have had for work with children.

SERVICES OFFERED BY THE CLINICS

The first question can be answered in two ways: in terms of amount of psychiatric service and in terms of the kinds of help offered. With respect to the first the 1935 census supplies some data. Table IV gives the figures in terms of average weekly hours spent by the psychiatrists in clinic work. For clinics meeting once or twice a month the hours of meeting were averaged to show the weekly rate, while in clinics served by more than one psychiatrist at a time the weekly hours were multiplied to take that into account.

These figures can be looked at from the point of view of the individual clinics or communities and from the point of view of the hospitals that supplied the staff. For the first the table indicates that most clinics were held once a month. This was the usual plan in New York, Pennsylvania, Michigan, and Illinois. About half of the total group of clinics operated in that way. One clinic in New York examined patients by appointment only. Six other New York clinics met only once in three months, and nine in other states met once in two months. Next to the monthly sessions, twice a month and once a week were the most frequent arrangements, the former being the practice of forty-four and the latter of fifty-three clinics. The twice-a-month plan was generally used in South Carolina and New Jersey, and the once-a-week in Massachusetts. Only eight clinics met daily. Six of these were held in state hospitals, and their frequent schedule usually indicated

TABLE IV

Distribution of state hospital clinics by duration (average number of psychiatric hours per week) and frequency of session, 1935

Number of Clinics with Given Average of Psychiatric Hours Per Week and Frequency of Meeting

	Under 1 hr.		1-2 hrs.			3-5 hrs.				6-8 hrs.				9-16 hrs.		27-39 hrs.	40 hrs. & over	Hrs. not stated					Total		
	Once a mo. or less	Once a wk.	Once a mo. or less	Twice a mo.	Once a wk.	Once a mo. or less	Twice a mo.	Once a wk.	Twice a wk.	Twice a mo.	Once a wk.	Twice a wk.	5-6 a wk.	Twice a wk.	5-6 a wk.	5-6 a wk.	5-6 a wk.	Once a mo.	Twice a mo.	Once a wk.	Twice a wk.	5-6 a wk.		Not stated	
California	1	-	1	2	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	5
Connecticut	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	1
Delaware	-	-	1	2	-	-	-	-	-	-	3	1	-	1	-	-	-	-	-	-	-	-	-	-	8
Illinois	11	-	1	-	-	-	-	1	-	-	1	-	-	-	-	-	-	1	-	-	-	-	-	-	14
Louisiana	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
Maine	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
Massachusetts	5	1	1	2	14	-	3	2	1	-	2	-	-	2	1	1	1	3	1	2	-	-	-	4	46
Michigan	3	-	12	-	-	-	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	2	-	19
New Hampshire	4	-	-	-	1	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	6
New Jersey	2	-	6	-	-	-	11	3	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	23
New York	17	1	47	6	11	-	2	-	1	-	1	-	-	-	-	1	1	-	-	-	-	-	-	4	92
Ohio	1	-	1	-	-	-	-	-	-	-	1	-	1	-	-	-	-	-	-	-	-	-	-	-	4
Oklahoma	1	-	1	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	3
Pennsylvania	9	-	24	-	-	2	2	-	-	4	1	-	-	1	-	-	-	1	-	-	-	-	-	-	44
Rhode Island	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	2
South Carolina	-	-	-	9	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	10
Washington	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
Wisconsin	-	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1
Total	54	2	96	22	27	2	20	10	3	1	12	2	1	3	2	3	2	6	1	2	-	-	10	-	281

that some member of the staff was available for examining patients at almost any time during the day. The other two were the Worcester Child Guidance Clinic, a stationary clinic with full-time staff, and the clinic of the Danville (Pennsylvania) State Hospital, which met in a health center in Wilkes-Barre for sixteen hours a week and accepted both adults and children as patients.

The table also shows the average number of hours per week the psychiatrists spent in clinical work. In fifty-six clinics this amounted to less than one hour a week on the average, the great majority of such clinics meeting once a month or less. The most usual average time was one to two hours per week. In 145 clinics—over half of the total group—this amount of psychiatric service was given. Fifty-one clinics provided from three to eight psychiatric hours, and five from nine to sixteen hours, per week. Five clinics, meeting daily, had the equivalent of a full-time psychiatrist.⁹

From the hospitals' point of view, however, the picture was somewhat different, since some hospitals provided a number of clinics to their surrounding communities. Table V shows the distribution by hospitals. If twenty-seven hours a week is considered full-time work (allowance must be made for transportation) it appears that nine of the sixty-eight hospitals gave the equivalent of one psychiatrist to clinic work. Five of these hospitals gave considerably more than that amount of time. The Delaware State Hospital, for instance, reported about forty psychiatric hours spent in the clinics each week. Two psychiatrists were assigned to this work. In Massachusetts the Grafton State Hospital gave an approximately similar amount of psychiatric outpatient service, and the Worcester Child Guidance Clinic had two full-time psychiatrists. Greystone Park, New Jersey, also had two psy-

⁹ Northampton and Worcester, Massachusetts; Binghamton and Willard, New York; and Eastern, Oklahoma. With the exception of the Worcester Child Guidance Clinic, sessions of these clinics were held in the state hospital building.

chiatrists giving full time in the Northern New Jersey Mental Hygiene Clinics, and Binghamton (New York) State Hospital psychiatrists spent over seventy hours per week in the clinics, almost wholly, however, in the one which met in the hospital itself.

TABLE V

Distribution of state hospitals according to average number of psychiatric hours given weekly to clinic service, 1935

	Number of Hospitals with Given Number of Hours of Service									Total
	Not stated	Less than 1 hr.	1-2	3-5	6-8	9-16	17-26	27-39	40 hrs. & over	
California	1	—	1	1	—	—	—	—	—	3
Connecticut	—	—	1	—	—	—	—	—	—	1
Delaware	—	—	—	—	—	—	—	—	1	1
Illinois	—	1	4	—	—	1	—	—	—	6
Louisiana	—	—	—	1	—	—	—	—	—	1
Maine	—	—	1	—	—	—	—	—	—	1
Massachusetts	2	—	—	2	2	2	1	1	2	12
Michigan	—	—	1	—	1	2	—	—	—	4
New Hampshire	—	—	—	—	1	—	—	—	—	1
New Jersey	—	—	—	—	—	1	1	—	1	3
New York	—	—	2	1	6	6	2	1	1	19
Ohio	—	1	—	1	1	—	—	—	—	3
Oklahoma	—	—	2	—	—	—	—	1	—	3
Pennsylvania	—	—	—	1	—	2	2	1	—	6
Rhode Island	—	—	—	—	1	—	—	—	—	1
South Carolina	—	—	—	—	—	—	1	—	—	1
Washington	—	—	—	1	—	—	—	—	—	1
Wisconsin	—	—	1	—	—	—	—	—	—	1
Total	3	2	13	8	12	14	7	4	5	68

On the other hand, over a third of the hospitals that maintained clinics for children or children and adults devoted less than six psychiatric hours per week to this work, and less than a fourth gave as much as eighteen hours to it. From neither the community nor the hospital point of view, then, does it appear that most of the state hospitals were devoting much time to preventive work. It is recognized, of course, that outpatient clinics are not and probably should not be the main concern of a state hospital. The situation is stated in this way

only to contrast it with the rather frequent statements in the literature to the effect that the state hospital should serve as the center for the mental health activities of the surrounding communities. Viewed from that angle the programs appear to be inadequate to the needs, and the question arises as to whether state hospitals can ever hope to supply a staff large enough to serve populous communities.

For data with respect to the kinds of psychiatric service offered by state hospital clinics we must rely chiefly upon the findings of the 1932 survey. Our investigators reported that most clinics limited their services to diagnoses of the patients' difficulties and recommendations for their care. Only a very few (two of which will be described in the succeeding chapter) offered psychiatric, psychological, or case work treatment. This situation was held to be due partly to the character of the clinics' intake, partly to the limited amount of time the staffs could give to clinic work. Further analysis suggests, however, that another contributing factor was the psychiatrists' conceptions of the function of a mental hygiene clinic, a factor itself associated with the character of the staffs' training for work with children.

Procedure in the clinics varied from place to place but the most general plan was to accept the patient for examination on the basis of a description of symptoms and social history (the latter often meager) presented by a nurse, teacher, social worker, physician, or relative. Some clinics began the examination, especially of children, with a psychometric test; others started with a physical examination, and in some clinics the psychiatrist was the first to interview the patient. This latter procedure was rather unusual, however, it being more customary to use the psychological or physical examination as a weeding-out method and to refer to the psychiatrist only those patients whose symptoms were not explainable on these grounds. In such cases the psychiatrist had before him, in

making his examination, the physical and psychological findings and the social history. On the basis of these and his interview with the patient he made his recommendations to the referral agents, sometimes in writing and sometimes verbally. Most of the clinics assumed no responsibility for "follow-up" work, although in a few cases they did allow the patient one or more return visits.

Such, more or less exactly, was the procedure in the majority of clinics. Some, however, used different methods. An example of a step toward greater individualization in the approach to patients was found in the clinics of the Medfield (Massachusetts) State Hospital. It was customary there to have the patient come to the clinic at least twice. On his first visit the social worker obtained a description of the outstanding facts about the child (most of the patients were children) from the person who accompanied him, the psychiatrist interviewed him briefly, and psychological and medical examinations were made. Before the child returned to the clinic a second time the social worker obtained more information about him, so the psychiatrist had at hand for his second examination a fairly complete social history and the results of the physical and psychometric tests. The work of attempting to put the clinic's recommendations into effect was usually left to the local visiting teachers or other social workers, but the clinic psychiatrist or social worker continued treatment in some cases.

This plan of having the clinic's social worker supplement the material descriptive of the patient and his background was fairly common among the clinics, but the number of clinics that offered further treatment to patients after the initial one or two visits was small. In fact, most clinics defined their work largely in terms of examination rather than treatment, a distinction that often seemed fairly valid in view of the nature of the patients' difficulties.

Among the few clinics that did include treatment of patients in their plans there was diversity of practice. In some of them treatment was left wholly in the hands of the psychiatrist. On the other hand, the psychiatrist of the Central Islip (New York) clinics, who frequently treated his child patients for a considerable period, was assisted by student social workers who, under supervision, worked with the patients' families and other persons in their environment. Some clinics, handicapped by lack of time and staff, supervised the local social agencies in the treatment of patients. This method was also followed in some cases by the few clinics that did offer treatment to patients, since case work agencies frequently desired this sort of service. Clinics of this latter type included in 1932 those of the Danvers (Massachusetts) State Hospital, the Northern New Jersey Mental Hygiene Clinics conducted by the Greystone Park State Hospital, and the Worcester Child Guidance Clinic. The latter two, representing as they do traveling and stationary programs that have much in common with the privately financed urban clinics, will be described in detail in the next chapter.

THE STAFFS OF THE CLINICS

This analysis of the services of the state hospital clinics leads us back to the second question proposed above: with what personnel were the clinics staffed and what were their duties and their professional preparation for the work?

The standard for urban child guidance clinic staffs that developed out of the Commonwealth Fund experimentation is a unit of psychiatrists, psychologists, and psychiatric social workers in a ratio that approximates 1:1:2 or 3. Many state hospitals, however, have been unable to adhere to this standard or do not consider it necessary to do so. The returns for the 1935 census of clinics provided data in regard to staff composition and showed that there was much variation among

the clinics in this respect. Table VI presents the figures arranged by states and clinics, since in some hospitals the staff varied from clinic to clinic. The threefold type of staff was found in less than a third of the clinics conducted under state hospital auspices. The most frequent combination was that of psychiatrist and social worker (forty per cent of the clinics), while twelve per cent of the clinics were manned by only a psychiatrist and in nineteen per cent the psychiatrist was assisted by a psychologist only.

TABLE VI
Distribution of state hospital clinics according to staff composition, 1935

	Number of Clinics with Given Staff Composition					Total
	<i>Psychiatrist only</i>	<i>Psychiatrist and psychologist</i>	<i>Psychiatrist and social worker</i>	<i>Psychiatrist, psychologist, and social worker</i>	<i>Not stated</i>	
California	2	2	—	1	—	5
Connecticut	—	1	—	—	—	1
Delaware	—	—	—	8	—	8
Illinois	6	—	8	—	—	14
Louisiana	1	—	—	—	—	1
Maine	—	—	1	—	—	1
Massachusetts	1	9	5	30	1	46
Michigan	—	3	10	6	—	19
New Hampshire	—	—	4	2	—	6
New Jersey	—	12	—	11	—	23
New York	14	4	71	2	1	92
Ohio	2	—	2	—	—	4
Oklahoma	3	—	—	—	—	3
Pennsylvania	2	23	—	18	1	44
Rhode Island	—	—	—	2	—	2
South Carolina	—	—	10	—	—	10
Washington	—	—	1	—	—	1
Wisconsin	1	—	—	—	—	1
Total	32	54	112	80	3	281

In Delaware alone all the clinics were of the threefold type, while among the states with more numerous clinics Massachusetts ranked first in proportion of clinics with staffs of this kind. Most of the numerous New York clinics were

staffed by a psychiatrist and a social worker, while in Pennsylvania most had a psychiatrist and a psychologist but no social worker.

The census returns gave no information as to the training or duties of the various staff members nor any indication as to why a particular combination of professional persons was used, but these questions were partially answered by the 1932 survey. If its findings are not now true of the particular hospitals for which they were reported, we know at least that the situation in the country as a whole remains essentially unaltered.

*The psychiatrists' training and its influence
on work with children*

It has been noted by many authorities that intramural experience does not provide an adequate background for psychiatric work with children.¹⁰ Yet, so far as could be learned, there was only one psychiatrist in a state hospital clinic in 1932 who had had formal training in child guidance before entering upon his present work. This was the director of the Worcester Child Guidance Clinic, itself unique in being the only full-time, stationary treatment clinic maintained by a state hospital. On the other hand, there were various examples of inservice training. The State Charities Aid Association arranged eight-week courses in child psychiatry for New York state hospital physicians. This provided for observation and discussions in such clinics as the New York Institute for Child Guidance and for lectures about and visits to numerous social agencies.¹¹ Somewhat similarly the University of Penn-

¹⁰ See, for instance, Adolf Meyer, "The Extra-institutional Responsibilities of the State Hospital for Mental Diseases," *Proceedings of the Meeting of the Joint Board of Trustees of the State Hospitals of Michigan*, held at the Kalamazoo State Hospital, July 20, 1916, p. 12, and H. C. Schumacher, "Practical Program for a Mental Hygiene Association," *Ohio State Medical Journal*, October 1932.

¹¹ "Contacts for Psychiatrists," *The Survey*, Vol. LXVIII (1932), p. 427.

sylvania has provided eight-week courses to which for a time one psychiatrist from each state hospital was sent. Another plan was that used in the Holmdel (New Jersey) Hospital. Before that hospital took over some clinics formerly staffed by the Greystone Park State Hospital, the psychiatrist who was to be in charge of them was assigned to work with the Greystone clinics for six months. In a few of the Massachusetts hospitals, the clinic psychiatrists had been given time for observation of and consultation with child guidance clinics in Boston. For the most part, however, the psychiatrists in the state hospital clinics had had no special training for work with children. Recently there have been some indications that this lack is being recognized and coped with. Pennsylvania for a time employed a psychiatrist trained in child guidance to work with state hospital staffs, and in 1937 a training program providing two-year fellowships in the Detroit Children's Center was undertaken in Michigan.

In addition to being handicapped by lack of training for work with children, the psychiatrists in many hospitals were able to give only a small part of their time to the clinic.¹² This seemed a necessary situation when a hospital had only a small outpatient clinic program, but arguments in its favor were advanced in other hospitals as well. On the one hand, it was held that a psychiatrist better retained his perspective on mental disease when he continued to have responsibilities for ward patients. On the other, it was argued that the benefits of contacts with the community should be spread throughout the psychiatric staff and not be confined to a special group.

Child guidance training, as distinct from the knowledge and techniques that can be acquired in a hospital for mental patients, implies specific orientation to the feelings and mo-

¹² In the following hospitals the clinic psychiatrists gave full time to that work: Massachusetts—Danvers, Northampton, Worcester; New Jersey—Greystone Park, Marlboro, Trenton; New York—Central Islip, Utica; Delaware; South Carolina.

tives of problem children, most of whom are not handicapped by neurological conditions or low intelligence. It includes supervised treatment of children, and work—direct or indirect—with their parents as the persons most concerned and most influential in the children's adjustment. Parents are looked upon not primarily as sources of information about the patients or as purely rational individuals who can carry out recommendations but as human beings whose feelings and wishes and emotional reactions must be taken into consideration in both diagnosis and treatment. Child guidance training also implies acquaintance with the social conditions and institutions that may play a part in the patients' problems and the organized resources of the community that may be of help in alleviating them. It is also training in "teamwork"—in specialization of function among psychiatrists, psychologists, and case workers and in union of efforts toward agreed-upon ends. Commenting upon the work of the state hospital clinics in California, a child guidance psychiatrist¹⁸ wrote:

The out-patient clinic provides a broadening experience for the hospital medical staffs and many communities are getting valuable diagnostic aid from them, particularly in regard to their adult problems. The chief difficulty is that most of the medical personnel of the clinics have had little or no training in child psychology. The tendency has been manifest, when confronted with a problem of childhood, to be concerned principally with diagnostic considerations and with the question of whether or not a psychosis exists. This approach has little value in most problems of childhood; formal classifications have little value and very few children show any evidence of a psychosis. A much greater value comes from understanding the child in a social setting, including the influences that have brought about behavior difficulties. Such knowledge involves good understanding of the child, the problems of his parents, and the various environmental factors influencing his development.

¹⁸ Frederick H. Allen, *Mental Hygiene Survey of the State of California*, Sacramento, California State Department of Social Welfare, 1930, p. 28-29.

The extent to which lack of training on the part of its psychiatrists appeared to handicap a clinic was found to depend partly upon the purpose which the clinic aimed to serve. If it received as patients chiefly feeble-minded and neurological cases, the fact that the psychiatrists had little experience with other types of children tended to pass unnoticed. The mentally defective children were assigned to the psychologist for testing, while the others were examined by methods that were largely medical. Recommendations in such clinics tended to be expressed in terms of placement or school adjustment for the children concerned, and the available community facilities for caring for them were easily learned. Many psychiatrists carried over from their inpatient practice a tolerant, sympathetic attitude toward human beings that stood them in good stead in their dealings with the clinic patients, their parents, and other interested individuals, and there was frequently widespread satisfaction with the work of such clinics.

On the other hand, some disadvantageous practices that were reported here and there seemed traceable to a too great preoccupation with the organic aspects of the patients' difficulties and to a lack of the understanding of feelings and motives that child guidance training might have provided. The social agencies in one city, for instance, reported that patients were upset because the psychiatrist dictated his reports in their presence. In other localities it was said that the psychiatrists knew little about approaching children and tended to treat them like rational adults. The insistence of several superintendents on having the clinics meet in the state hospital buildings was another point of dispute. Social workers and others who knew the patients' families reported that they met with much objection to the clinics on this account. A visit to the "crazy house" put a blot on a child's and a family's reputation that was hard to erase.

The fact that psychiatrists had not had training in child

guidance seemed also the explanation for certain difficulties that arose within the clinical group and in their relationships with the community. That some clinics found it hard to secure and retain competent trained social workers seemed attributable partly to this situation. Administrative procedures carried over from a mental hospital organization created in other clinics unnecessary handicaps to easy relationships with other social agencies. As seemingly minor a matter, for instance, as the fact that the clinic's correspondence had to be signed by the superintendent caused difficulties in one center. That rule led to delays in reports, handicapped the director in making spontaneous decisions, and, by the use of hospital letterheads, added to the stigma the patients already attached to examination at the clinic. About other clinics there were complaints that the psychiatrists did not understand the limitations and functions of schools and social agencies and that recommendations were such as could not be carried out under their jurisdiction. And in some communities in which the social agencies were staffed by psychiatric social workers there was criticism of the clinics because diagnoses and treatment plans were not based on the type of dynamic psychiatry in which the social workers had been trained. Not all of these objections seemed remediable, since some of them grew out of differences of opinion about psychiatric theory itself. For the most part, however, they seemed traceable to mental hospital practices and ways of thinking and indicated a lack of appreciation of the attitudes of the outside world that probably would have been avoided if the psychiatrists' training had included experience in child guidance.

Training and duties of social workers

The role of the social worker in a clinic, her training and her duties, seemed largely a function of the total conception of a clinic's objectives. Table VI indicated that by 1935 the

custom of having a social worker on the clinic staff was well established, more than two thirds of the clinics being so equipped. Among the states with many clinics, only Pennsylvania had a high proportion without a social worker. In such clinics information about patients was furnished largely by the local social workers or members of the school staff who referred them—a practice that was not limited to these clinics, however.

Although the majority of clinics did have staff social workers, the training of these workers and the work assigned to them was not generally that which has become standard practice in urban child guidance clinics. This situation can be considered adequately, however, only against the background of what the clinics aimed to do and what their methods of procedure were. In the first place it must be remembered that the great majority of these clinics served adults as well as children. In the second place, most of them were diagnostic clinics which proceeded upon the theory that the advice about what the patients needed could be put into effect by the teachers, nurses, social workers, and others who brought the children to the clinics' attention. The limited amount of time that a staff could spend in a community (later tables will give the data on this point) and the number of patients to be seen were frequently cited as the necessities that forced such a theory upon them, although many directors were apparently satisfied with the plan and agreed with its assumptions.

As would be expected, the duties of the social workers varied widely. At one extreme there were clinics in which the social worker's chief task was to take notes for the psychiatrist during his interviews. More generally—in fact, usually—she spent most of her time collecting material to supplement the social histories of the patients. Sometimes she acted as the clinic manager, arranging appointments and interviewing the persons who accompanied the patients to the clinic. In a num-

ber of clinics she gave the psychometric tests. There were few clinics, however, in which the social workers had an opportunity to use the technical skills that training in case work would presumably give them. Interpretation of findings to social agencies was usually made verbally or through written reports by the psychiatrist. Only a few clinics attempted to supervise or consult with local workers regarding the carrying out of recommendations. Still fewer provided their own case work service. The usual procedures of case work with child guidance patients—counseling with parents, discussing the problems with schools and recreation centers, trying to effect various types of modification in the patients' environment—were usually left to local persons who, for the most part, were not trained for such work.

The use of local workers appeared to be satisfactory to some communities and to be deplored in others. A rather common complaint of state hospital clinics was that the social histories submitted with applications for examination were usually inadequate. Some clinics reported that they had surmounted this difficulty by instructing local workers in history taking; others said that case conferences attended by representatives of the community were very helpful in this respect. Another difficulty was found in the lack of trained social workers in the local agencies, which frequently meant lack of understanding of the significance of the clinics' recommendations. Case conferences and lecture courses for nurses, teachers, and social workers were used by some clinics as a corrective of this difficulty. On the other hand, some clinic directors said that they found it satisfactory work through public health nurses, visiting or school nurses, and probation officers. An example of this latter situation was found in the clinic conducted by the Warren (Pennsylvania) State Hospital in the schools of Erie, where there was a visiting teacher and the school authorities were very cooperative.

The question of the place of the social worker in state hospital clinics seemed thus to have two aspects. It involved, on the one hand, the further question of whether the clinic could afford to offer case work treatment or consultation service to the communities it served. Was such service necessary as an aid to putting the clinic's recommendations into effect? Were local resources adequate to this task, and, if not, could the clinic surmount the difficulties by an educational program? To a considerable extent the answer to these questions varied with the objectives of the clinics and the types of patients they received. Our survey did not yield data to show what happened to relatively similar patients under diverse treatment situations but, by and large, the referring agents, at least, seemed satisfied with little case work service as long as the patients were chiefly the feeble-minded and those with neurological involvements.

On the other hand, however, there was the question of the use of the case worker within a clinic. It seemed to some directors that to use a social worker for supplementing history material and for doing various sorts of secretarial work was not making the most effective and efficient use of this member of the staff. Doubtless the histories do frequently need supplementing, they said, but the more important task of the social worker in this area is to obtain understanding of the parents' attitudes and desires with respect to the patients. Even with the feeble-minded or the neurologically handicapped child the question at issue is not only what is the cause of his difficulties but what the parents are able and willing to do about it. Then, too, traveling clinics are particularly in need of a kind of liaison officer, somebody who can interpret to them the personalities and resources in the community and can carry on an educational program. Some few clinics used their social workers in this manner and reported very satisfying results.

Viewed in this way, the requisite training of the social worker is apparently not wholly dependent upon the types of patients the clinic serves. If the clinic offers case work treatment to the child guidance type of patient the social workers doubtless need a somewhat different emphasis in their preparation for the job, but there are some basic essentials in approaches to people and appreciation of their motives that would be needed by any social worker in a clinic. No accurate data are at hand by which one can judge just how nearly this ideal was realized but the survey of clinics showed that there was more variation in the equipment of social workers than of any other member of the clinics' staffs. At one extreme stood the Northern New Jersey Mental Hygiene Clinics, whose requirement was that social workers be graduates of approved schools of social work and have at least two years' experience in working with a psychiatrist.¹⁴ The Worcester Child Guidance Clinic also required training in psychiatric social work, as did a considerable number of hospitals that used the inpatient staff for clinical work. At the other extreme there were a few clinics in which the social worker's chief qualification for the job was a period of experience at the hospital telephone switchboard! Between these were social workers whose training was wholly of the apprenticeship type and others who had been psychiatric nurses, psychologists, or other professional workers. Many of them had become good, practical social workers. Some had supplemented their original training by various types of brief courses of lectures and summer sessions at schools for social work. In general, there was considerable correspondence between the qualifications of the social workers and the duties to which they were assigned, although in a few centers dissatisfaction had arisen

¹⁴ The state's civil service requirements for the position of psychiatric social worker are much like these.

out of the disparity between their training and their official status.

The clinics' psychologists

The situation with respect to the clinics' psychologists was somewhat similar. Since so much of a state hospital clinic's work consists of psychometric testing, it would seem essential that this work be in well-qualified hands. Table VI showed that less than half of the clinics had a psychologist on the staff. Some met this deficiency by using local psychologists, attached to schools or courts. No comments upon the advantages or disadvantages of such an arrangement were made in the course of our survey but it seems likely that arguments can be advanced in favor of either practice. The use of a local psychologist may be one means of tying a traveling clinic more closely to a community, especially if the psychologist is connected with the public schools. On the other hand, the need for experience in teamwork and in handling psychiatric cases may weight the balance in favor of a psychologist attached to the clinic staff.

Other methods of surmounting the lack of a psychologist seemed less satisfactory. In a few clinics the psychiatrists did the mental testing, and in a larger number the social workers were used for this purpose. If the individuals concerned have adequate training in the two fields such a union of functions may work satisfactorily. Psychological tests have been used by some psychologists as an opening to child guidance examination and treatment much as the physical examination is used by some psychiatrists. On the other hand, the giving of adequate mental tests is itself a lengthy procedure. When to that are added the other services a psychologist can render (tutoring and conferring with regard to various types of training and retraining), it would seem that most clinics need a quali-

fied person who can give his full time to this work, especially if the clinic is to do more than make diagnoses.

CLINIC QUARTERS AND SCHEDULES

The 1935 census provided one further statistical item—that showing in what quarters the clinics were held. Thirty-one clinics held sessions in the state hospital building. The most frequent locations, however, were a general hospital (sixty-four clinics) or a school building (forty-eight clinics). Health centers, courthouses, and various types of welfare agency offices stood next in order of frequency, about sixty clinics altogether being housed in such quarters. City halls or other types of municipal buildings were also frequently used. A few clinics met at the headquarters of the Red Cross or of the visiting nurses, in libraries, and in Y.W.C.A. buildings. Five were given space in a business building, and one, the Worcester Child Guidance Clinic, had a building of its own.

The 1932 survey of the clinics indicated that the quarters of most clinics appeared to be satisfactory so far as neighborhood and equipment were concerned. There were some comments about inadequate housing, however, that threw light on the broader question of the clinics' relationship to their patients and the community in general. In one city, for instance, it was noted that the hospital conducted one clinic in the crowded stock room of the board of health and another in a well-furnished suite of rooms provided by the juvenile court. A marked difference in the attitude of clients and community to the two clinics was noted, there being a definite aversion to attendance at the health center. Another clinic reported that its contacts were hampered by the setting provided by a local hospital. The clinic was given very inadequate space, and the patients' waiting-room had as its chief decoration cases of medical instruments! In another city one

clinic was held in the detention home and served children awaiting court action and those on probation. Parents seldom accompanied the children to this clinic, whose atmosphere meant punishment to most of the children. Another in the same city met in dark, dingy, rather dirty rooms provided by a settlement house. The neighborhood was very poor, and the clinic's referrals were confined to children brought to it by social workers.

These few examples made it clear that there is probably a close relationship between the auspices and equipment of a clinic and the response it receives from the community. Popular opinion of all that savors of mental disorder being what it is, any clinic works under handicaps. It was said in Worcester, for instance, that the clinic, in spite of its excellent, homelike building in a residential area, was considered by many of its neighbors as the "place for crazy people." How much more damaging is it to a child's reputation and self-esteem, then, if he has to attend a clinic that is housed among the poor and outcast, ill furnished (as if he were not worthy of anything better), and associated with crime or mental disease?

Another practice having some bearing upon the attitude of the patients toward the clinic was that of appointments and the number of patients examined per session. Considerable variation among the clinics was found. Some clinics did not make appointments for interviews, and many did not conduct separate sessions for children. In favor of the former practice was said to be the public's preference of coming to the clinic without making arrangements beforehand. Against it were cited the crowded character of some sessions, as well as the bad effects that waiting produced on some patients. Clinics that did not schedule appointments examined sometimes as many as thirty patients a day, and ten or fifteen were not infrequent numbers. Those that did make appointments

with patients tended to accept from four to eight a day, somewhat more time being allotted to child guidance patients than to other types.

CONCLUSIONS REGARDING SERVICE FOR CHILDREN
UNDER STATE HOSPITAL AUSPICES

These cross-section descriptions of the state hospital clinics, of the services they render and the patients they serve, lead to some fairly definite conclusions. Most generally stated, it appears that a program of child psychiatry under the auspices of a mental hospital meets with many difficulties, some of which are due to the psychiatric point of view of the hospital and to staff equipment, some to the limitations inherent in semi-rural work, and some to the feelings of the public about mental hospitals and mental disorders. Where there was criticism of the clinics (and it must be remembered that in many communities their work was described as very helpful), it centered largely about the lack of consultation and treatment. A clinic is apt to offer such services, however, only if it subscribes to a point of view about mental disorders which is different from that on which much hospital psychiatry is based. Even then, there are numerous practical difficulties that stand in the way.

Dr. William Bryan of the Worcester State Hospital has recently pointed out that social work, mental clinics, and mental hygiene have developed largely outside the mental hospital and that many hospital superintendents have been suspicious of these new movements. "The mental hospital," he says, "has not been an outstanding factor in mental hygiene programs."¹⁵ Our survey seems to substantiate that statement. It has been shown that in only nineteen states (including Maryland, in which the state hospitals cooperate with

¹⁵ William A. Bryan, *Administrative Psychiatry*, New York, W. W. Norton & Co., 1936, p. 21.

the State Board of Health in a small clinic program) did any state hospital offer clinic services to children, and that in half of those states extremely few children were examined. A fourth of the hospitals that did provide clinics examined less than fifty children a year, and a third of them gave less than six hours of a psychiatrist's time per week to the clinic, which usually served adult as well as child patients. Although the clinics varied, most of them confined their work to diagnosing and making recommendations regarding the care of feeble-minded and neurologically disabled children. Very few offered psychiatric assistance to children who suffered from less obvious and more clearly emotional disabilities. Only a third of the clinics had a staff composed of psychiatrist, psychologist, and social worker, and in only one clinic was the psychiatrist specifically trained for work with children. The clinics were used largely by courts, schools, and social agencies and were generally distrusted or ignored by the medical profession and the parents of problem children. In other words, to put it briefly, there was little evidence that state hospitals had been much influenced by child guidance theory and practices.

In addition to these broader aspects of the work, our survey produced some more specific findings. It disclosed that a tie-up between a clinic and any particular group in the community tends to limit the kinds of cases that are referred and the work that is done with them. It appeared that courts and schools usually send to the clinics the more extreme types of cases and usually want diagnoses in terms of intellectual and organic causes, on the basis of which placement of the children can be effected. Social agencies, on the other hand (at least in the more progressive communities), tend to refer less extreme cases and want the clinics to treat the children or, at least, advise agencies in regard to methods of treatment. If the clinics are not equipped for such work—as most of them are not—dissatisfaction is apt to arise, for very few clinics have

defined clearly just what they conceive their function to be. Similar results sometimes appeared when clinics engaged in a widespread program of community education. The need to arouse understanding and support was felt by many clinics, but they frequently found that an enlightened public could make demands upon them for service which were greater than they were prepared to meet.

It may be held, of course, that child guidance is not the function of a state hospital clinic, and it can be shown that, to some extent, the diagnostic purpose of the state hospital clinic determines the composition of its staff, the professional preparation and duties of its members, the number of patients examined, and the kind of service given to them. In clinics whose patients are largely the feeble-minded and the neurologically defective, the psychologists do much of the work, and the psychiatrists contribute chiefly a neurological examination. Generally the social worker, if present at all, supplements the history reports or does a kind of secretarial work. Her training is usually commensurate with such tasks. Community relationships are not usually greatly stressed by such clinics, and they tend to work through one or two groups, such as visiting nurses or schools or courts.

The clinics' diagnostic work with feeble-minded and neurological cases was frequently described by informants from outside the hospital as very satisfactory. The growth in demand for clinic services and the clinics' own interest in securing variety in patients tend, however, to push clinics in the direction of encouraging the referral of problem children whose difficulties are not organic. Even if this were not so, there would probably be children whose difficulties are of psychogenic origin among the patients of any clinic. Our survey of the clinics seems to throw doubt on the hospitals' ability adequately to serve such patients, and, indeed, there was some question whether completely satisfactory service to

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any group of children can be rendered by a staff whose outlook is that of the typical state hospital. Although the needs of children suffering from various handicaps are different in terms of psychiatric, psychological, and case work service, there are certain common requirements in the understanding of human motivations and feelings that are essential for staff members regardless of what type of patient is being dealt with. It is unfortunately true, as Adolf Meyer long ago pointed out, that in many state hospitals psychiatrists are not interested in this aspect of psychiatric work. Since, however, the public's attitude toward anything savoring of mental disease is what it is, it may be somewhat fortunate that state hospitals have not played a larger part in child guidance work.

CHAPTER SIX

Case Studies of Two State Hospital Clinics

IT has been suggested in the preceding chapter that the traveling clinics of a state hospital may find it difficult to offer the psychiatric and case work treatment that is needed by children severely maladjusted emotionally. Detailed descriptions of individual clinics would perhaps make this conclusion more evident. There is so much in any clinic's history and working methods, however, that depends upon local circumstances that adequate analysis would entail a volume in itself. On the other hand, the cross-section method of the previous chapter seems to need some supplementation by individual histories in order to give more life to the figures and the generalizations. We offer, therefore, brief accounts of the development and work of two programs that have put into action some of the principles discussed above—the Northern New Jersey Mental Hygiene Clinics and the Worcester (Massachusetts) Child Guidance Clinic.

NORTHERN NEW JERSEY MENTAL HYGIENE CLINICS

The Northern New Jersey Mental Hygiene Clinics, under the official direction of Greystone Park State Hospital, are of particular interest because they are conducted by a fairly large staff that devotes its full time to mental hygiene work with children and adults, offers treatment as well as diagnostic service, and does no work with paroled patients. These clinics opened in 1926 with the aim of reducing the number of admissions to the hospital through early diagnosis and treatment. They were known as preventive clinics and were held in three county seats—Elizabeth, Paterson, and Hackensack. They were staffed by the clinic director and an assistant psy-

chiatrist from the hospital, assisted by social workers from the parole department, and met half a day twice a month. During the previous years patients had been examined by appointment at the hospital and, if necessary, were referred to the social service department for assistance. The hospital had no parole clinics (and never has had them) but it was thought that some patients on parole might want to use these new clinics and that they should not be excluded from them. It was early discovered, however, that to have such patients in a clinic's waiting-room discouraged other people from attending. To get around this difficulty an appointment system was worked out, and later the parole work was separated entirely from that of the mental hygiene clinics.

At the time that the preventive clinics were established it was the intention to offer service chiefly to adults, but there were immediate requests from schools and social agencies that children also be accepted as patients. This was due in part to the current interest among social workers and educators in mental hygiene and child guidance and in part to the earlier work of the social service department of the hospital in making contact with the social agencies and institutions in the communities. The original request for a clinic for adults had come from the social workers of one of the towns, and later several general hospitals asked that clinics be established. The program, therefore, began in a favorable situation. Within two years interest in work with children had developed to the point where two psychiatrists with special training and experience in community programs were engaged for full-time work, and several social workers were transferred from the hospital to the clinic staff. Later (about 1929) four trained psychiatric social workers replaced the hospital workers, and the staff became wholly distinct from the hospital staff.

By this time clinics had been set up in eleven centers, many

of them on the initiative of the hospital rather than at the special request of people in the community. Consequently some interpretative work was necessary. The usual plan was to discuss the opening of a clinic with the social workers in the chosen town, to make contact with some local physicians and prominent citizens, and to secure some newspaper publicity. With regard to the latter method, however, it is to be noted that it was discontinued once a clinic was established. Further "educational" work was carried on chiefly through lectures by the staff to professional groups, churches, and parent-teacher associations. Community response has varied, of course, but during the more than ten years that the program has been in operation none of the clinics has had to be discontinued because of lack of interest.

Of special interest to our study are the relationship of the clinics to the hospital and the professional qualifications of the staff. Technically, the order of authority is the State Board of Control, represented by the Commission on Institutions and Agencies, the hospital superintendent, and then the director of the clinics. In fact, however, the work of the clinics is carried on fairly independently of the hospital, since all the staff are engaged full time and have no contact with the hospital patients, either in the institution or on parole. With one exception the clinics meet in centers away from the state hospital (for the most part in general hospitals) and in other ways function almost as though they were a separate organization. The central offices of the New Jersey clinics are located on the hospital grounds.

As to the technical equipment of the staff, the Northern New Jersey Mental Hygiene Clinics are also unusual. The two psychiatrists who were engaged in 1928 to enlarge the program had been trained in the Commonwealth Fund Demonstration Clinics, and while later psychiatrists have been less specifically trained for the work, they too have had

more experience with children before their appointment to the staff than is usual in state-supported clinics. The psychologists, too, have been technically trained, and the standards for social workers are unusually high. The chief social worker, who has been on the staff since the clinics began, is a trained psychiatric social worker, and civil service standards require that her assistants be graduates of accredited schools of social work and have at least two years of psychiatric experience when appointed. In 1938 the clinics' staff consisted of two psychiatrists, two psychologists, a chief social worker and six others, and from four to six students from schools for social work. This distribution of staff personnel contrasts sharply with that of many other state clinics and indicates that case work treatment is an important part of the clinics' services.

Originating with clinics in three communities, including the state hospital, the program had expanded by 1928 to serve eleven centers and in 1938 served nine, two clinics having been transferred to the supervision of another state hospital. For the greater part of the clinics' history, then, the following communities and their surrounding areas have been served: Elizabeth, Plainfield, Morristown, Passaic, Newton, Newark, Franklin, Paterson, Englewood, Jersey City, and Hackensack.¹ There are two distinctly different types of communities in this group. Bergen, Essex, Hudson, and parts of Morris and Passaic counties are densely populated areas containing communities (Newark, Jersey City, Paterson, and Passaic) of well over 100,000 population. The rest of the area covered (Sussex, Warren, and parts of Morris and Passaic counties) is definitely rural. It is maintained by some observers that the clinics might now better concentrate their services on the rural sections of the state, since ten years of demonstration would seem sufficient to have shown the cities

¹ The Elizabeth and the Plainfield clinics have been transferred to Marlboro State Hospital.

the meaning of mental hygiene work and to have stimulated them to set up clinics of their own.

Clinics are held in seven of these communities from ten to five o'clock twice a month, while the other two communities receive the same service once a month.² On the average about thirteen patients are seen for examination or treatment at each session. Six clinics are staffed by two psychiatrists and a social worker assisted by one or more student workers; the other three clinics have one instead of two psychiatrists. Friday mornings are devoted to a staff meeting, and no clinics are held on Friday afternoon or Saturday. With the present staff this schedule gives each psychiatrist one day in each two weeks (excluding the usual Friday and Saturday) in which he is not in a clinic. Four of the six social workers and their students attend clinics twice a month, and two social workers attend once a week. The rest of the social workers' time is given to case work in the communities. The chief social worker spends most of her time in the central office and attends clinics only in emergency situations.

The Friday meetings are attended by the whole staff and, at times, by representatives of social agencies, schools, and medical groups. Most of the new patients examined during the week are briefly described and discussed, and recommendations for treatment are made by the psychiatrists. The weekly statistics are also checked at this time. The number of new cases per week varies considerably, depending in part upon how many patients are scheduled to return for psychiatric re-examination or treatment. The general rule is to schedule four cases for each psychiatrist a day and four for the psychologist, making something like fifty cases to be reported upon each week. The case workers' active loads vary from a hundred to one hundred and seventy-five cases apiece. This includes all open cases in the district, many of which are not

² Data from Mildred Hurley, Chief Social Worker, Northern New Jersey Mental Hygiene Clinics, June 1938.

assigned for case work treatment, since they are carried co-operatively with other agencies. In addition, about a third of the cases receive psychiatric treatment only, and many others are given only psychological examinations. Consequently, the active load of treatment cases averages about seventy for each case worker and her student.³

The procedure in a clinic session is as follows. Patients come to the clinic by appointment. If they are referred by a social agency, histories describing their family situation, the development of their symptoms, and so on are prepared by the agency and, usually, sent to the central office before the patient is examined. Similarly reports of physical examinations and of school records are submitted. In the clinic the patients and those who accompany them are met by the social worker, who reviews and, if necessary, supplements these reports before the psychiatric or psychological examination. All persons under sixteen years of age are examined first by the psychologist and are referred to the psychiatrist only if personality disturbances are evident in that examination.⁴ After these examinations the persons accompanying the patient to the clinic are interviewed by the psychologist or psychiatrist (whichever one made the final examination) and recommendations for the patient's care are given to them. If the psychiatrist deems it necessary, children's cases (and adults as well) are assigned to the social workers for further treatment, with or without additional psychiatric interviews. A recent statement by the director of the clinic says that "it is the social worker's duty to see that the recommendations of the psy-

³ Ibid.

⁴ Although—almost by the nature of the situation—there are no data by means of which the efficacy of this procedure can be tested, it seems questionable whether a psychiatric clinic should leave to the psychologist the decision as to whether a child does or does not need psychiatric treatment. This practice has doubtless been adopted here because so many feebleminded children are referred to the clinics, but a more flexible procedure would seem to be preferable—one, for instance, in which the psychologist would be the first examiner only in cases referred specifically for intelligence tests.

chiatrist are carried out, i.e., she must interpret to the family or to the patient the detailed meaning of the recommendations and work out with the patient, patient's relatives, social agencies, etc., practical methods of applying these recommendations . . . and assist in securing the care which the recommendations request. . . . It is also her duty, when necessary, to continue the psychotherapy started by the psychiatrist."⁵

In actual practice much of the treatment is carried by the social workers, for intervals between return appointments for psychiatric interviews are usually several months in length. In children's cases their activity is confined largely to case work with parents, teachers, and others who are in charge of the patients.

As with most clinics, the character of the intake has changed with the years. The chief social worker writes that "at first the majority of patients referred by social agencies, schools, physicians, and court officers were either the feebleminded or psychotic, or else the chronically dependent of inferior mentality. This use of the clinic was so well recognized that the individual who referred himself or was referred by friends because of social inadequacies came furtively, fearful that he would be seen and labelled as a mental case."⁶ A vigorous educational program changed the character of the referrals considerably. It may be of interest to note here that, in the opinion of the chief social worker, case work demonstration might have been sufficient to secure this change in referrals had the clinics not been so widely discussed and enthusiastically received by the communities that more rapid interpretation of their function seemed essential.⁷ Whether that interpretation had an equally satisfactory effect upon patients' atti-

⁵ *Duties, Personnel, and Routine of the Northern New Jersey Mental Hygiene Clinics*, mimeographed statement for the use of the staff.

⁶ Mildred H. Hurley, "Practical Aspects in the Development of a Mental Hygiene Clinic," *The News Letter*, American Association of Psychiatric Social Workers, Vol. VI (1936), No. 2, p. 7.

⁷ *Ibid.*

tudes toward the clinic is hard to say. It has been noted by one case worker that patients who are ordinarily treated in a general hospital are most reluctant to go to the state hospital office for interviews when the psychiatrist is unable to come to the usual place of meeting. On the other hand, most of the case workers find that under the usual circumstances patients do not associate the clinics with the mental hospital.

In 1937, referrals to the clinics came most frequently from schools (thirty-one per cent), social agencies (twenty-six per cent), and physicians and hospitals (fourteen per cent). During the years of the clinics' operation there has been an upward trend in the proportion of cases referred by schools, nurses, and courts, and a decline in the number referred by private physicians. The number of self-referrals and referrals by friends has always been small—for example, about seven per cent of the total intake in 1932. There has been a change also in the relative proportions of children and adults. In 1928 seventy-five per cent of the patients were children (that is, sixteen years of age or under); in 1935, fifty-seven per cent; and in 1937, sixty-six per cent.

In June 1938, the open case load of the clinics was 1,258. The exact composition of this group is not known, but earlier studies (to be described below) have shown that although the clinics receive very diverse types of patients much of their time is still spent in examining the feeble-minded. These latter children and their families are rarely given any form of treatment beyond that of the diagnostic examination and recommendations.

The cost of operating these clinics is difficult to measure accurately, since the central headquarters are provided by Greystone Park State Hospital. Prior to 1932, about \$40,000 a year was appropriated for the maintenance of clinics, and recent annual budgets have been around \$45,000. Most of this money is spent for salaries.

Of special importance to our study is the extent to which the communities' needs are met by services such as these given by the Northern New Jersey Clinics and whether there is any indication that the towns and cities are being stimulated to set up clinics of their own. With respect to the first question it is obvious that no definite answer can be given. It was noted, however, that in spite of the fact that these clinics meet more frequently than many other comparable ones and that their case work staff, in particular, is relatively large, the demand for their services far exceeds the supply. Appointments for examination of patients are made many months in advance, and the intervals between psychiatric interviews are so long (several months in most cases) that it would seem that the interviews must almost necessarily be in the nature of a check-up rather than of treatment. The social workers endeavor to counterbalance this with home visits, but they too have case loads that are excessive if much case work treatment is to be expected.

Work with children has been particularly regarded by the state department as a demonstration, and it has been said at times that the objective is to have the counties, perhaps through the educational authorities, eventually take over the child guidance part of the program. Little progress in that direction appears to have been made, however—a situation that is duplicated in other states that look upon state-financed clinics as demonstrational in nature. On the other hand, the educational work of the clinics appears to have been fairly successful, and it may be that it is in this area that the clinics have most adequately served the mental well-being of children. Through the clinics' efforts, courses for the training of tutors for reading disability have been set up, interest in securing facilities for the care of postencephalitic, birth injury, and endocrine cases has been aroused, schools have been assisted to plan programs for variously handicapped groups of

children, and mental hygiene courses have been given to parent-teacher associations, theological seminary students, and nurses.⁸ In so densely populated an area as that of Northern New Jersey it may be that clinics fulfill their chief function by such services.

The Northern New Jersey Mental Hygiene Clinics have thus developed an organization and working methods that appear most nearly to combine some of the practices of typical urban child guidance clinics with those of traveling clinics. Noteworthy among the similarities to the child guidance clinics are the use of trained psychiatric social workers, the offering of psychiatric treatment to patients judged to be in need of it, and the affording of case work treatment to those families that are not referred to the clinics by case work agencies. Differences are to be seen in the extensive use of the psychologist as the initial examiner in children's cases, in the acceptance of many feebleminded children for examination, and in the predominance of home over office visits by the social workers. The Northern New Jersey Clinics have thus been enabled to overcome at least two of the obstacles to rural work under state hospital auspices which our survey revealed—the use of a staff whose interest is chiefly in intramural work, and the need to rely upon local workers for the carrying out of treatment recommendations. It seems pertinent, therefore, to describe briefly the findings of a series of studies that have been carried on in these clinics,⁹ for they afford some data as to what is to be anticipated when traveling clinics operate under reasonably favorable conditions. The studies

⁸ Mildred Hurley, *op. cit.*, pp. 7 f.

⁹ They were made by students of the Smith College School for Social Work. These students were assigned to the Northern New Jersey Clinics for field training and spent nine months there as student case workers. The studies were conducted under the joint supervision of the School and the Clinics and were presented as individual theses in partial fulfillment of the requirements for the degree of Master of Social Science.

give information on the following topics: the general characteristics of the clinics' intake, what various sections of the community apparently want from the clinics as judged by their referrals, results achieved through the treatment of children, the extent to which institutionalization of patients has been prevented or postponed, the value of school surveys, and the activities of the clinics' social workers in treatment.

A survey of the intake of the clinics for the year July 1931 to July 1932¹⁰ showed that of the 962 patients twenty-eight per cent were persons over twenty years old, thirty per cent were twelve to twenty, thirty-four per cent were six to eleven, and eight per cent were under six years old. Social agencies, schools, and health agencies were the most frequent source of children's cases, the first two referring about a fourth of the child patients, respectively, and the latter a fifth. Referrals from private sources constituted eighteen per cent of this intake. Twenty-eight per cent of the total group of patients were examined by the psychologist only, while seventy-four per cent had at least one interview with a psychiatrist. The former type of service was particularly frequent in children's cases, thirty-seven per cent of the children under seventeen years of age being in that group. It was associated also with the intelligence of the patients, although not to the extent which might be expected. In general, the distribution of the children by intelligence categories was as follows: superior, three per cent; average, forty-two per cent; borderline, twenty-five per cent; mentally deficient (moron, imbecile, idiot), thirty per cent. Psychiatric examination was not confined to children of the higher intelligence levels, however, for the following was the distribution of

¹⁰ Unpublished theses by Eva Christianson, Mary Gates, and Fay Goleman, Smith College School for Social Work, 1934, on file in Smith College Library. Published in abstract form in *Smith College Studies in Social Work*, Vol. V (1934), p. 211.

such cases: superior intelligence, five per cent; average, fifty per cent; borderline, thirty per cent; mentally defective, fifteen per cent. Nor did the omission of the psychiatric examination indicate in all cases that the clinics gave no service beyond that of psychological testing, for forty-four per cent of the cases listed as "psychological only" involved more than one interview, and in sixteen per cent from five to over twenty interviews were held with persons in or outside the family.

The same survey gave information as to the amount of treatment afforded by the clinics and the apparent outcome at the time the cases were closed. As to the former question it was shown that sixteen per cent of the cases of children examined by the psychiatrist did not extend beyond the initial set of interviews (that is, interviews with the patient and the persons accompanying him to the clinic), that in thirty-nine per cent of the cases from one to five additional interviews were held by one or another of the members of the clinical staff, and that in eleven per cent there were twenty or more interviews. Although this amount of treatment is far less than that afforded in urban clinics which are predominantly treatment institutions,¹¹ it does represent an unusual amount of service from a traveling clinic staff.

As to outcome of treatment, the numbers and proportions as found in a random sample of two hundred of the 443 pa-

¹¹ Comparable figures are available for the Judge Baker Guidance Center's Treatment Division for 1931 and 1932 and for the Institute for Child Guidance, New York, clinics which represent the opposite extremes in terms of hours per case. They show the following distribution of cases by number of interviews:

Interviews <i>Number</i>	JBGC <i>Per cent</i>	ICG <i>Per cent</i>
10 or less	12	5
11 to 20	35	19
Over 20	53	76

From an unpublished thesis by Margaret Quick on file in Smith College Library and an article by Helen Witmer and Students, "The Outcome of Treatment in a Child Guidance Clinic," *Smith College Studies in Social Work*, Vol. IV (1933), p. 341.

tients under twenty years of age who were examined by a psychiatrist are shown in Table VII.

TABLE VII

Condition of the patient at the close of treatment or at the end of an eighteen months' period if the case was still open

<i>Condition of Patient</i>	<i>Number of cases</i>	<i>Per cent of total cases</i>	<i>Per cent of known cases</i>	<i>Per cent of treated cases</i>
Adjusting successfully	24	12	16	19
Improving but still under treatment	38	19	27	30
Some improvement; case closed	16	8	11	13
Unimproved	47	24	32	38
Institutionalized after little or no treatment	21	10	14	—
Unknown—consultation case, transferred to another clinic, or family moved away	54	27	—	—
Total	200	100	100	100

This distribution compares rather favorably with those found in other clinics. The proportion of the treated cases making a good adjustment is similar to that reported for the Judge Baker Guidance Center's Treatment Division in the same years and not significantly lower than that of the Institute for Child Guidance.¹² On the other hand, the proportion of unimproved cases is twice as large as in those clinics, a situation which is doubtless traceable to numerous factors, not least of which may be the students' definition of lack of improvement. In this connection, it is to be noted that the proportion of cases listed in Table VII as showing "some improvement" is much lower than that usually rated as "partially adjusted." In addition, another student reporting on 100 treated cases of the Northern New Jersey Clinics closed in 1935 rated twenty-five per cent of the children as successfully adjusting,

¹² Ibid. See also Helen Leland Witmer, "A Comparison of Treatment Results in Various Types of Child Guidance Clinics," *American Journal of Orthopsychiatry*, Vol. V (1935), p. 351, where it is shown that the proportion of cases in these various categories remains rather constant from clinic to clinic.

sixty per cent as somewhat benefited, and only fifteen per cent as unimproved.¹³

Another series of studies had to do with the use of the clinics by various professional and lay groups in the communities.¹⁴ Reviewing the 206 children's cases closed between May and October, 1935, the students found that forty-two per cent had been referred to the clinics by social agencies (including hospitals, courts, and churches), a similar proportion by schools, and the remaining 16 per cent by private individuals. Sixty-eight per cent of the referrals from the first group, fifty-seven per cent from the second, and forty-seven per cent from the third were children whose intelligence was found to be borderline or inferior. A third of the children referred by private individuals and a fourth of those referred by schools belonged to families whose economic status was classified as "comfortable," so it was clear that persons of all economic levels were using the clinics.

Three main types of service were requested of and given by the clinics. A diagnosis only (chiefly in terms of intelligence level) was requested in nearly half of the agency-referred cases, in about a fourth of the school cases, and in only three per cent of those in which a private individual asked for assistance. Requests for diagnosis and recommendations as to treatment characterized almost all the other agency cases, twenty per cent of the school cases, and 18 per cent of those referred by private individuals. Treatment by the clinic was desired in five per cent of the first group, sixty-two per cent of the second, and seventy-nine per cent of the third group of cases. These proportions were somewhat al-

¹³ Florine Jackson Ellis, unpublished thesis, Smith College School for Social Work, 1935; on file in Smith College Library. Published in abstract form in *Smith College Studies in Social Work*, Vol. VI (1936), p. 277.

¹⁴ Elizabeth Griffin, Anne Hill, Ruth McElroy, unpublished theses, Smith College School for Social Work, 1936; on file in Smith College Library. Published in abstract form in *Smith College Studies in Social Work*, Vol. VII (1936), pp. 158, 159, 161.

tered when the services actually given were classified. The clinics, for instance, limited the diagnostic type of service to clear-cut cases of mental deficiency, with the result that a fairly equal proportion (about thirty per cent) of the cases from each type of referral source received that sort of service. Nearly half of the cases referred by schools and social agencies were given the diagnosis-and-advice type of service, while twelve per cent of the agency cases, twenty-four per cent of the school cases, and seventy-four per cent of those referred by private individuals received psychiatric or case work treatment.

These studies gave definite evidence that treatment is handicapped when parents do not have a part in deciding whether or not they want it. This question arose in only a few of the agency-referred cases, many of which involved only diagnosis or advice to the referring parties. The majority of the agencies were courts, hospitals, child-placing organizations, and others that wanted to know whether the children were intellectually handicapped or had other reasons for their unusual behavior. With schools, however, the situation was somewhat different. It was found that teachers were able to use suggestions involving classroom management and transfer of pupils to other grades but treatment of the child by the clinic was a different matter. Fifty per cent of such treatment cases had to be closed because of lack of cooperation on the part of schools or parents, and it was reported by the student that there was definite evidence in some cases that the school's insistence upon a child's attending the clinic enhanced the parents' attitude of non-cooperation. In contrast, only twelve per cent of the cases referred by private individuals had to be closed because of lack of parental cooperation. Even more striking evidence of this inability of parents (and teachers as well) to utilize a service for which they did not originally feel a need was offered by a recent follow-up study of the

clinics' "school surveys,"¹⁵ in which fairly large groups of children who were not adjusting in school had been selected by five schools for examination by the clinic. Over a third of the 115 children were found by the clinic to be in need of psychiatric study. In only eleven cases did the parents bring the children to the clinic, and of the seven of these who were then found to be in need of psychiatric treatment only one case continued beyond the first interview.

Another series of studies gave evidence as to the extent to which the clinics were able to postpone or prevent institutionalization.¹⁶ Covering two years' intake of the clinics (1931 and 1934), two students reported that nearly half of the patients (adults and children) appeared to be eligible for commitment to institutions according to state law. They were distributed as follows: feeble-minded—forty-eight per cent; delinquents—thirteen per cent; psychotic—fourteen per cent; other severe personality disorders—seventeen per cent; convulsive disorders—eight per cent. Institutionalization was immediately recommended for about half of these patients, the proportion varying decidedly with the diagnostic groups. For instance, ninety-four per cent of the low-grade feeble-minded were judged in need of institutional care as contrasted with sixty per cent of the high-grade feeble-minded group, and only twenty-five per cent of the delinquents and thirty per cent of the persons with severe personality disorders were considered institution cases. Follow-up studies of the treated patients made two years after their first examination by the clinic showed that fifty-seven per cent were improved in social adjustment and the remainder were equally

¹⁵ Dorothy Lyons, unpublished thesis, Smith College School for Social Work, 1938; on file in Smith College Library. Printed in abstract form in *Smith College Studies in Social Work*, Vol. IX (1938), p. 193.

¹⁶ DeEtta Shoemaker Taylor and Jane Wood, unpublished theses, Smith College School for Social Work, 1935 and 1938; on file in Smith College Library. Printed in abstract form in *Smith College Studies in Social Work*, Vol. VI (1936), p. 283; Vol. IX (1938), p. 161.

divided between those unimproved but still in the community and those who had been placed in institutions. The various diagnostic groups were fairly evenly distributed with respect to adjustment.

A final group of studies of interest in our survey of state-supported services deals with the role of the social workers in children's cases.¹⁷ One hundred cases in which both psychologist and psychiatrist participated were studied, half of them being cases referred by schools and half by private individuals. The average number of social workers' interviews per case was less in the former group, being 7.7 as compared with 11.5. The difference was accounted for chiefly by the more frequent interviews with mothers in the privately referred cases. There were eight school-referred cases and six privately referred cases with which the social worker had no contact. It was found that the social workers' services could be categorized as follows: securing additional history (8 private and 21 school cases); securing a report of the child's progress (34, 35); attempting to effect environmental adjustments (29, 17); attempting to alter attitudes through giving an understanding of the child's behavior (23, 11); interpreting child guidance principles and the clinic's recommendations (30, 22); and attempting to help the parent to gain insight into his own problems (13, 12).

It was thus apparent that the Northern New Jersey Mental Hygiene Clinics are using their social workers for much the same type of case work as that which characterizes most child guidance clinics, so that our original judgment was confirmed that these clinics do illustrate a means of adapting child guidance to rural areas. It is to be noted, however, that

¹⁷ Genevieve Jansen and Myrtle MacKensie, unpublished theses, Smith College School for Social Work, 1938; on file in Smith College Library. Printed in abstract form in *Smith College Studies in Social Work*, Vol. IX (1938), pp. 138, 139.

the problem of securing referrals predominantly of a child guidance type has not been solved (it is not clear that these clinics desire to have only that type of referrals but such is the objective of some clinic systems), and that the more important problem of offering services in such a way that large numbers of parents feel inclined to use them has barely been touched upon.

WORCESTER CHILD GUIDANCE CLINIC

Among clinics administered by state hospitals the Worcester (Massachusetts) Clinic is unique in several respects. It is a stationary clinic, housed in its own building in the city and remote from the state hospital grounds. It has a large, full-time staff, well trained in child guidance, and accepts only children as patients. It offers to them psychiatric, psychological, and case work treatment. Except for its hospital connection, the Worcester Clinic is hardly to be distinguished from the city child guidance clinics which have succeeded the demonstration clinics of the Commonwealth Fund program. Yet, like most other state hospital clinics, this clinic originated in the early efforts of the hospital to provide outpatient service for patients on parole and for other individuals who might be regarded as potential patients. If the providing of complete mental health services to a community is considered the ultimate function of a state hospital, it would seem that the Worcester State Hospital has come nearest to attaining that objective.

The hospital's outpatient service was opened in 1921 and followed the usual plan of scheduled sessions in which adults and children were examined and recommendations for their care given. It soon became apparent, however, that in spite of the hospital's best efforts at education, the general public's attitude toward the clinic was one of prejudice and fear. In

Two State Hospital Clinics

1923, therefore, the outpatient clinic was discontinued, and a mental hygiene clinic for adults and children was opened in a general hospital which was high in the community's favor. At the same time a habit clinic for young children was established in the Temporary Home and Day Nursery, this project being a demonstration requested by the newly formed Division of Mental Hygiene of the State Department of Mental Diseases. To both of these clinics, which met weekly, the state hospital supplied a psychiatrist, a psychologist, and a social worker from its own staff.

Interest in the clinics developed rapidly among many of the social agencies and schools of Worcester. In fact, much of the original demand for mental hygiene work came from them, and they were the chief source through which patients came to the clinics. Further strengthening of the position of the clinics as agencies of the community was achieved by weekly case conferences attended by social workers, teachers, and other professional persons and by contacts with Clark University and other institutions. The favorable and understanding reception which the schools and social agencies gave to child guidance work is attributable largely to the activities of the psychiatrist who was assigned by the hospital to the clinics from 1925 to 1929. At that time the only social workers available were the students in training at the hospital, so the psychiatrist personally made many visits to schools and social agencies and spent much time in talking to individual principals, teachers, and social workers about the children they had referred to the clinic and about mental hygiene in general.

Within a short time the Habit Clinic was discontinued and its work was taken over by the Mental Hygiene Clinic. Later, separate provision was made for adults, and the clinic was limited to child guidance. For five years this clinic continued on a part-time basis, staffed by psychiatrists, psychologists,

and social workers from the state hospital and receiving increasing numbers of children as patients.

In 1928 came a change that may be significant in the evolution of a state hospital clinic program. The Worcester Welfare Federation contributed \$2,500 to the clinic and so made possible the employing of a full-time psychiatric social worker, in addition to meeting some pressing incidental expenses. The next year the Federation increased its contribution to \$3,800, and the next to \$4,200, and it has continued to give the clinic financial support in spite of the economic depression. In the meantime (in 1930) the state legislature made a special appropriation of \$15,000 to the hospital for clinic work. With these funds the clinic was put upon a full-time basis. A psychiatrist trained in children's work by the Judge Baker Foundation was engaged to head the clinic, and two psychologists (one for half-time work), three psychiatric social workers, and one clerical assistant were employed out of hospital funds. The Welfare Federation's contribution was used to pay the salary of a chief social worker and another clerical worker. To this staff were added student social workers (four from the Smith College School for Social Work and two from the State Department of Mental Diseases) and two internes in psychiatry from the hospital staff. In this way the Worcester Child Guidance Clinic became a well-equipped organization, the joint project of the community, the hospital, and the state. Officially it remained under the direction of the state hospital, but practically the Director was free to adapt its policies to the community's needs. By reason of its independent housing (at about this time the clinic left the Memorial Hospital and bought a dwelling house in a residential part of the city) and management, it is probable that the general public began to associate its activities less and less with mental disease, and the clinic was thus able to pay more attention to children amenable to child guidance treatment.

For a clinic of this type the problem of community education is quite different from that of traveling clinics clearly associated with state hospitals. It has already been shown that the clinic started in a favorable atmosphere, in that in the early days considerable demand for the clinic came from the social agencies of the city. Weekly case conferences of the staff, to which representatives of agencies and other professional individuals were invited, had been a feature of the clinic from the outset. Later in the clinic's history, when it was believed that as much as possible had been achieved in showing these people the kind of cases the clinic was equipped to handle, the case conferences were confined to representatives of agencies whose cases were under discussion.

In 1926 an Advisory Committee for the clinic was organized. It consisted of about twenty professional persons—physicians, lawyers, educators, social workers, and others—and served both to keep the clinic in touch with outside opinion and to interpret the clinic to the community. Out of this committee grew the Child Guidance Association, with its executive committee, which meets monthly, its board of directors, and a general membership. The latter contains a large group of people, fairly representative of the community at large, who meet annually and are kept informed of the clinic's activities by means of informal bulletins. The Board of Directors, representative of the various professions and the laity, was carefully selected to advise the clinic about matters of community relationships and broad policy.

In addition to these avenues of interpretation of the clinic to the public (and of the public to the clinic) the Worcester Child Guidance Clinic has followed the plan of many others in giving considerable time to lectures to parent-teacher organizations, church groups, and the like. In fact, the clinic has had as one of its specific purposes the education of the community in mental hygiene principles. The aim has been to

show the public in what kinds of cases the clinic can be of most service and to increase the understanding of the emotional life of children in general. In the opinion of the staff the first objective, at least, has been fairly well achieved, as evidenced by the gradual change in the character of the referrals to the clinic.

More direct than these approaches to the agencies and individuals of the community have been several specific plans for fostering cooperation between the clinic and other social agencies. In 1931 the director of the clinic was influential in securing the services of a specially trained probation officer from the Boston Juvenile Court for a three-month study and stimulation of relationships between the Worcester Juvenile Court and the social agencies of the city. In addition, the clinic has given special services to certain social agencies, such as routine psychiatric examination of all the clients of an agency for unmarried mothers, and has worked particularly closely with the court.

With such a staff and such a program for interpreting the clinic's function it may well be asked what kind of cases are referred to the clinic and by whom, and what services are given. Between 1926 and 1929—that is, before the full-time staff was engaged—the clinic had an average of 166 new cases per year. In 1930 the number rose to 274 and has remained at about that level. The 1936-37 annual report notes a total of 555 cases open at one time or another during the year, 227 of which were new cases. With these patients the psychiatrist had over a thousand interviews, while social work contacts numbered 1,980.

The largest group of patients (thirty-eight per cent) in 1936-37 were referred to the clinic by relatives; juvenile court referrals were next most frequent (thirty-two per cent), and those from social agencies accounted for most of the others. Referrals from schools and private physicians were

infrequent.¹⁸ This distribution is considerably different from that reported for 1930, when the clinic was first put on a full-time basis. Then social agency referrals topped the list (forty per cent); private referrals accounted for but twenty per cent, while schools and courts each referred fifteen per cent of the patients. To the court the clinic gives chiefly an advisory type of service, but the great majority of the other patients are treated by the staff, either alone or in cooperation with social agencies.

In general, the work of the clinic has continued to follow the philosophy under which it was originally set up. It may well be that that continuity in point of view is the chief reason for the success of this clinic, which started as a demonstration but has been accepted as the joint responsibility of the community and the state. The following extract from the report of the Director in 1927 still describes fairly adequately the clinic's methods and objectives.

It has been very definitely our conviction that the task of the clinic was not merely that of offering advice as to the problems presented by individual children—much less that of placing labels on them as some expected—but also that of impressing upon the public the need for such individual study of maladjusted children as the clinic attempts to do. The fundamental test of the success of the clinic, therefore, lies in the extent to which the community shows acceptance, active participation and support. The methods are in general those employed by the "child guidance clinics" organized by the National Committee for Mental Hygiene under the Commonwealth Fund. No matter what specific problem any given child may present which brings him to the clinic, the attempt is made to visualize him with his capacities and his handicaps reacting in a certain way to a definite situation. This is, if you will, axiomatic in modern psychiatry but unfortunately it has not been axiomatic in studying children and their failures

¹⁸ Source of referral may be partially a matter of clinic policy. School referrals to the Worcester clinic were said to have declined because the staff often suggested that teachers request mothers to make direct referrals. The staff made no consistent effort to find out who sent parents to the clinic.

—precisely where the psychiatric method of personality study would seem most applicable. . . .

There seems no question in the minds of those knowing the work of the clinic that it offers a resource of real value to those dealing with problem children or even the problems which normal children present. On the other hand the increasing public support and the continuous demand for such help on many sides has convinced the hospital that the work has justified itself from many angles—even that of better community contacts for the hospital itself. There seems no doubt that many communities and many hospitals would discover similar mutual advantages in such relationships.¹⁹

¹⁹ Henry B. Moyle, "A Children's Clinic as a State Hospital Contribution to the Community," *Bulletin of the Massachusetts Department of Mental Diseases*, Vol. XI (October 1927), p. 4-5.

CHAPTER SEVEN

Clinics Conducted by Psychopathic Hospitals

THE provision of psychiatric clinics for children by state hospitals, it has been shown, was the final stage in the expansion of the hospitals' function to include after-care treatment of patients and other measures looking to the prevention of mental disease. Through such clinics the hospitals' services are extended to individuals not seriously ill mentally, and—it has been indicated—many superintendents still question whether this is a proper function for a state hospital to assume. With the psychopathic hospitals few such doubts arise. These hospitals are definitely set up to observe and offer temporary care for persons suffering from incipient, obscure, or transitory psychoses; they stress voluntary commitment and prophylactic treatment, and they serve as training centers in which medical students may observe and study the early stages of mental diseases. It is therefore clearly within their province to conduct clinics which are concerned with early diagnosis and preventive measures.

The first stage in the evolution of the separate psychopathic hospital occurred in the 1870's with the establishment of observation wards for neurasthenic patients in general hospitals in Germany. These were soon followed by clinics, both in the hospitals and in university medical schools. American experiments with this kind of service came later, but as early as 1893 the General Hospital of St. Francis in Pittsburgh made provision for wards for mental patients,¹ and outpatient clinics for nervous and mental patients were established in some general hospitals in the early 1900's. To some extent it

¹ L. Vernon Briggs, "Observation Hospitals or Wards for Early Cases of Mental Disturbance," *Boston Medical and Surgical Journal*, Vol. CLVIII (1908), p. 474-80.

was from the experience of physicians in such clinics that the demand for psychopathic wards or hospitals arose.² Dr. L. Vernon Briggs observed in 1906:

Seldom a day passes during which clinics are held in the mental department of the Boston Dispensary when one of the three physicians to that department . . . does not feel the crying need for such a hospital. Many patients come to the Dispensary today, or are attended at their homes by physicians, who have to remain in their present surroundings, which often are the cause of their trouble. . . . There is no place where you may send such cases, excepting to the insane hospitals, and many of them are not insane, for their mental disorders are often the result of disturbed metabolism or acute autointoxication, or of disturbed habits of mind and body brought about from their surroundings, or improper food and sleep.

A psychopathic ward was established in the Albany Hospital in 1902, and the first separate psychopathic hospital was erected in Michigan in 1906, in connection with the state university.

Three of the present six state-financed psychopathic hospitals have a state university connection (Michigan, Iowa, and Colorado). The others are part of the state hospital systems—notably the Boston Psychopathic Hospital, the Syracuse (New York) Psychopathic Hospital, and the Psychiatric Institute of the State of New York. All of them have outpatient clinics, but their emphasis on children's work varies greatly. Somewhat akin to these clinics are those conducted directly by medical schools under the department of psychiatry. The University of Minnesota, for instance, maintained several traveling clinics in 1924 and 1925 and still has one in Minneapolis, and somewhat similar outpatient services are offered by the medical schools of numerous universities. The University of Kentucky Medical School has conducted a child guid-

² L. Vernon Briggs, "Observation Hospital for Mental Disease," *Boston Medical and Surgical Journal*, Vol. CLIV (1906), p. 696.

ance clinic for several years and recently (about 1938) the University of Oregon initiated a clinic program that includes traveling as well as local units.

From the point of interest of this book—that of states supplying psychiatric services to children—the psychopathic hospitals and state university medical schools present a rather confusing picture. Offhand one would be inclined to think that a hospital of fifty to a hundred beds, set up mainly for research and teaching purposes, would not be the logical center for a statewide program of children's clinics, but actually some of the states in which they are located have no other sources of psychiatric service. Then, too, the urban psychopathic hospitals in Boston and Syracuse, and the New York Psychiatric Institute, would be expected to have somewhat different functions from those of hospitals directly connected with university medical schools. In practice, however, there is no such clear-cut demarcation between the two hospital types. The Boston Psychopathic Hospital conceives its function as one of serving the psychiatric needs of the community; the New York Psychiatric Institute is chiefly interested in research and training of psychiatrists, while the Syracuse Psychopathic Hospital, at the time of our 1932 survey at least, rather discouraged the attendance of children at its clinics, preferring to work through the clinics of the State Department of Mental Hygiene instead. On the other hand our investigators found that the university hospitals ranged in their attitude from that of Michigan, where little work with children was done, to Colorado, where the hospital was envisaged as the logical center for statewide activities. The latter point of view can be justified on the basis of a state university's extension function, the providing of children's clinics to the people of the state being paralleled by the agricultural and other educational programs of the university extension service.

Since the number of psychopathic hospitals that conduct

clinics for children is small and their programs varied, it seems that their manner of functioning and their problems can best be set forth by individual descriptions of those that considered outpatient work with children one of their main activities. In this category were the Boston Psychopathic Hospital, the Psychopathic Hospital of the University of Colorado, and the New York Psychiatric Institute. The latter, however, had moved in 1931 from its old quarters on Ward's Island (where it had been set up by Adolf Meyer) and its present greatly enlarged program of services was instituted at about the time the material on which this study is largely based was collected. It is not possible, therefore, to describe and discuss its services in the manner of the other two. In addition, there are several reasons for concluding that the Institute's program does not have a great deal of bearing on the main problem of our investigation—how clinic services can be provided to children who live outside a metropolitan area. The Institute is located in New York City. Its main function is the training of psychiatrists and research.³ It has affiliations with a large medical center and can draw upon numerous social resources for aiding in the treatment of its patients. In such a situation many of the problems that form the subject matter of this book disappear, and the others that arise are scarcely within the scope of our study.

In spite of certain resemblances to the Psychiatric Institute's clinic, the outpatient department of the Boston Psychopathic Hospital seemed of value to our study, both because of its historical importance and because, by contrast with the

³ The 1933 Annual Report of the Psychiatric Institute notes that "in the admission of children to the children's hospital service preference is given to those cases which are of value because of research interests or teaching needs." The 1934 report says that the children's service "has provided teaching material for both undergraduate and post-graduate medical students and students in psychiatric social work" and that "the whole matter of the treatment of psychiatric disorders in children in a psychiatric hospital or outpatient department may be regarded as a research problem."

Worcester Child Guidance Clinic, it illustrates so well how differently psychiatric service to children is conceived by hospital administrators and those who conduct stationary child guidance clinics. The Colorado Psychopathic Hospital offers additional data on this subject and also illustrates how a city hospital carried out a rural program. Finally, a description of the now abandoned program of the Iowa Psychopathic Hospital will be included in this chapter because it was unique in several ways and because an unusually detailed analysis of its findings was available.

BOSTON PSYCHOPATHIC HOSPITAL

The establishment of the Psychopathic Department of the Boston State Hospital in 1912 marked the successful culmination of a legislative campaign "to obviate the necessity of taking mentally ill people to prisons and to give them early hospital care and treatment."⁴ From the beginning it contained an outpatient department which accepted children as well as adults as patients, nearly half of its first year's intake of 830 being adolescents and younger children. The director, Dr. Elmer Southard,⁵ noted in this first year's report:

The out-patient department has been especially successful. . . . Social agencies of various descriptions, particularly those dealing with children and adolescents, have hastened to send their problems to the Psychopathic Hospital. . . . There can be no doubt that the work of the out-patient department, upon the diagnoses of various grades, especially the higher grades of imbecility, upon juvenile court problems, upon sex problems connected with adolescence, upon incipient cases of insanity and cases of fear of insanity, upon speech disorder, and, most important of all, upon after-care and prophylactic work in connection with house cases, amply justified its existence.

⁴ L. Vernon Briggs and Collaborators, *History of the Psychopathic Hospital, Boston, Massachusetts*, Boston, Wright & Potter Printing Co., 1922, p. xvi.

⁵ Quoted by Douglas A. Thom in a chapter, "The Out-Patient Department," in L. Vernon Briggs, *History of the Psychopathic Hospital*, op. cit., p. 154.

From the outset, then, this clinic received the variety of cases and worked with the variety of social institutions and agencies which clinics under the auspices of state hospitals frequently have had to put forth considerable effort to interest. In 1922, when the history of the hospital was written, it was noted that the child patients were mainly of two types: feebleminded or mentally defective delinquents, referred chiefly by the juvenile court and penal institutions, and those who suffered "from the effects, pre-eminently, of poor housing, poverty, desertion, and the like, all of which evils are based upon or laid down upon the background of mental inadequacy."⁶ To them the outpatient department gave social, psychological, and psychiatric examinations, on which diagnoses, prognoses, and advice in regard to disposition were based. The clinic's part in treatment was confined chiefly to sending reports to the referring agencies, telling of the clinic's findings and recommendations. A few children were asked to return to the clinic for further study, and the social service department followed some of the non-agency cases in an attempt to see that the recommendations were carried out. That the need for further work with children was early recognized, however, is shown by the fact that the first "habit clinic" to be established in Boston (a type of clinic later sponsored by the Massachusetts Department of Mental Diseases) was an offshoot of the Psychopathic Hospital's outpatient department. It was held one afternoon a week in a settlement house under the auspices of the Baby Hygiene Association and was headed by Dr. Douglas Thom, then chief of the outpatient department. Its intake was limited to young children who had developed "undesirable habits," and treatment was carried on through individualized parent education.⁷

The Boston Psychopathic Hospital was a pioneer in the

⁶ Ibid., p. 157.

⁷ Ibid., p. 160. See also Chapter VIII of this book.

field of psychiatric social service as well as in the extension of psychiatry to children whose difficulties were considered due to environmental influences. These two interests of the hospital's first director, Dr. Southard, were closely interrelated. He was one of the leaders in the movement that stressed the psychiatric aspects of numerous social problems (delinquency, poverty, industrial maladjustment, and the like), and he viewed the social worker as the liaison officer between the hospital and the community. One of his early memoranda regarding the hospital notes:

The need of a social service in the new Psychopathic Hospital became obvious at once when the plans were tentatively discussed in 1909-10, and the obvious need was expressed in so many words in the State Board of Insanity's report in 1910.⁸

A chief of social service was appointed a year after the hospital opened in 1912, and both paid and voluntary workers and students were utilized from that time on. The trend, however, was away from the volunteer. The director's report for 1916 urged that instead of two paid workers and varying numbers of volunteers at least seven paid workers be engaged.⁹ This request was not granted, but the hospital did from the beginning attest to its interest in professional social work by offering apprenticeship training in that field. The course was one of six to eight months' duration. In 1918-19 the hospital joined with Smith College in preparing social workers for service in the army neuropsychiatric hospitals, out of which experiment developed the Smith College School for Social Work.¹⁰

From the beginning social service was set up as a separate department of the hospital as a whole, rather than being assigned specifically to inpatient or outpatient work. Most of

⁸ *Ibid.*, p. 172.

⁹ *Ibid.*, p. 157.

¹⁰ *Ibid.*, chapter on "The Social Service, 1913-1918" by Mary C. Jarrett, p. 180.

its attention, however, was given to inpatients, its chief contribution to outpatient work being the clinic manager. Of her functions Miss Jarrett,¹¹ the first chief of social service, wrote in 1922:

It was apparent at once that a clinic manager to look out for social interests in the out-patient department was essential, to get the social history from patients or friends who came with them, to assist in discovering social problems of the patients and their ability to carry out the physicians' directions, to see that patients and others were made comfortable and understood the situation, and to act as a go-between for the physicians and outside social workers.

The chief of the outpatient department at that time also stressed the importance of the clinic manager's services, saying:¹²

There is no part of the out-patient personnel that contributes more to the efficiency of the organization than a well-trained clinic manager. The position should be filled preferably by a qualified psychiatric social worker, who should devote her entire time to the interests of the clinic. Her duties are numerous and varied. In the morning, while the clinic is in operation, she is the one who makes the first contact with the patient and those accompanying him. By virtue of her training and experience, she should be capable of taking histories if the pressure of work demands it. She is the keeper of the records, and it falls upon her to see that the innumerable details necessary for the reports [to the agencies] are correctly and completely recorded.

It was customary at that time—and the practice has been continued—for the examining psychiatrist to secure the information necessary to supplement the social histories submitted by the referring social agencies. Only if additional data are needed do the hospital social workers participate in an outpatient case, and then only at the request of the psychiatrist. Similarly social treatment is undertaken in only a

¹¹ *Ibid.*, p. 175.

¹² *Ibid.*, p. 166-67.

small proportion of the outpatient cases, the majority being dealt with through the medium of reporting letters to the responsible social agencies. These letters are customarily written by the psychiatrists, although the director by 1922 was advocating that the clinic manager should compile the reports from the physicians' summaries of findings and so save their time for other work. He added that, in addition, the clinic manager is "usually able to present the case in a way that is more satisfactory to the social organization than the average physician can do," especially since "in a very large per cent of all the reports sent out from an outpatient clinic, the social aspect predominates."¹³

It would seem, then, that in spite of the Psychopathic Hospital's early interest in psychiatric social work, its use of such workers, in the outpatient department at least, is considerably at variance with standard child guidance practice. The only full-time social worker in the department—the clinic manager—has many necessary but rather secretarial duties to perform, and the social service department itself is called upon to participate in only those cases not referred to the clinic by social agencies. Some such cases do receive social treatment, but the decision to treat or not to treat rests with the psychiatrist rather than being the result of joint consideration of a threefold staff. Actually, however, the other patients are frequently given more assistance than the case records indicate, for the clinic manager interviews the patients informally before and sometimes after they see the psychiatrist and gives some informal interpretation of findings to the agency representatives.

Patients come to the outpatient department from a wide variety of sources. A survey of intake in 1937¹⁴ revealed about

¹³ *Ibid.*, p. 168.

¹⁴ Margaret G. Phoutredes, unpublished thesis, Smith College School for Social Work, 1938, on file in Smith College Library. Published in abstract form in *Smith College Studies in Social Work*, Vol. IX (1938), p. 135.

the same distribution as was found in 1932. Family and children's agencies made over a fourth of the referrals, as did hospitals and private physicians. Referrals by parents, relatives and friends, and by the patients themselves constituted about fourteen per cent of the cases. Court and school referrals were relatively few, comprising about eight per cent of the total and sixteen per cent of the children's cases. The 1937 study showed, in addition, that twenty-six per cent of the patients were under eleven years old and thirty-five per cent between eleven and nineteen. About half of the children were of at least average intelligence. The patients in general were of the following types: children brought for examination prior to adoption or placement (seventeen per cent), children who were not adjusting in school (eight per cent), children with "multiple neurotic traits" (five per cent), persons (adults and children) with disorders of conduct (twenty per cent) or mental deficiency (nine per cent), psychoneurotic or psychotic trends (thirty per cent), others (eleven per cent).

Sessions are held daily from nine to one, adults and children waiting together for their examinations. Three or four patients per psychiatrist are studied or treated at each session. The usual procedure for the examination of children is as follows. The clinic manager obtains routine information from the person who accompanies the child to the clinic, the psychiatrist supplements the social history data by interviews with the relatives or accompanying case worker, and he and the psychologist then examine the patient. The findings of the examination are transmitted to the referring social agency by letter and some additional interpretation of the clinic's point of view is given by the examining psychiatrist in a brief interview with the social worker or parent who accompanied the child to the clinic. In some cases this part of the work is carried by the clinic manager.

A study made by the Boston Survey staff of the Massachu-

setts Society for Mental Hygiene in 1930 indicated that in their opinion the reporting letters were inadequate, since recommendations based on the psychological examination were usually lacking and there was little psychiatric interpretation of the case. The letters were said to include diagnosis and mental rating but very little discussion of either and very few suggestions for treatment. The diagnoses at that time were stated largely in terms of intelligence ratings (for 491 of the 562 child patients examined in 1929 this was the only diagnosis) or such descriptive terms as conduct disorder, speech or reading defect, neurotic or normal child. It may have been that the psychiatrists' and clinic manager's informal conversations made up for these deficiencies, but otherwise there was little to indicate that the hospital exercised much control over the use to which its findings were put.

The 1937 survey mentioned above¹⁵ gave further details about the work of the department. It was there shown that fifty-five per cent of the patients were interviewed only once by a psychiatrist and fourteen per cent more did not return for a second interview although further appointments for them were made. Case work was carried only mainly through the referring agencies, the social service department of the hospital being utilized in only eight per cent of the cases. In other words, the outpatient department offered predominantly a diagnostic or brief-treatment type of psychiatric service and social treatment was seldom provided.

Such a policy with respect to case work treatment is probably traceable to several factors that distinguish a hospital outpatient department from a child guidance clinic. The first and most important is the medical orientation and organization of a hospital. It has been noted that from the start the Boston Psychopathic Hospital was cognizant of the social needs of its patients and the interrelated character of social

¹⁵ Ibid.

and psychiatric disabilities. Nevertheless the interest was primarily a medical one. The psychiatrists recognized that in order to understand the patients they needed descriptions of their social and familial circumstances, and that recommendations for the patients' care were apt to go astray unless some trained and responsible person were available to carry on the work of interpretation and encouragement. In other words, the hospital's interest in the social aspects of patients' problems represented the incorporation into psychiatry of certain social considerations. These considerations broadened psychiatry but left social work processes relatively untouched, for the psychiatric social worker, under this conception, is essentially a medical social worker in a new specialty. In contrast, modern developments in psychiatric social work emphasize the contributions of psychiatry to case work practice, and the adaptation of psychiatric techniques to case work with people whose difficulties are expressed in terms of social relationships. The child guidance clinics combine such case work treatment of the parents with psychological or psychiatric treatment of the patient. A similar conception of work and division of function could, doubtless, be utilized by a psychopathic hospital, but it is not at all surprising to find that the more strictly medical attitude prevails.

Another factor contributing to the hospital's characteristic use of social workers is the staff organization. At the time of our study the hospital had about a hundred beds and cared for about two thousand inpatients a year. In the outpatient department about nine thousand patients were examined. To this department were assigned two full-time psychiatrists and two others who gave the combined equivalent of about a day a week to the work, and the clinic had in addition the almost full-time services of a volunteer psychiatrist. The psychological staff consisted of two full-time workers. Social service was represented by the clinic manager, and, in addition, the

equivalent of the time of one and a half workers in the social service department was reserved for outpatient work. With such relative proportions of professional services and the number of patients to be studied, it is clear that case work of the child guidance type could not be carried on with any large number of patients even if it were desired. In addition, there was the fact that about eighty per cent of the cases were referred to the hospital by case work agencies for diagnosis and recommendations.

The outpatient department's aim from the outset has been "to meet the psychiatric needs of the community."¹⁶ In so far as this has been achieved, it has been made possible largely through the cooperation of other social agencies. The work of the department itself has been largely diagnostic. No patients are refused its services, but very few receive long-continued treatment. In general, then, the outpatient services of the Boston Psychopathic Hospital represent psychiatry's contribution of diagnosis to preventive work with a wide variety of cases. It is a psychiatry that is socially and psychologically oriented, that takes into consideration social pressures and the dynamics of emotional life; but it is still a didactic psychiatry, one that prescribes a regimen of life rather than one that offers its patients help in working out their own solutions to their difficulties. This point of view is typical of much of the best hospital psychiatry and is elaborated upon here only because the Boston Psychopathic Hospital was one of the first to develop such an outlook and has been a leader in the field.

COLORADO PSYCHOPATHIC HOSPITAL

The clinical program of the Colorado Psychopathic Hospital is of interest chiefly because it was so frankly educational, its main objectives being to give its own staff familiarity with social conditions in rural communities and to interest

¹⁶ L. Vernon Briggs, *op. cit.* (n. 4), p. 162.

the general public in mental hygiene. Since this is a point of view about clinic work that has been persistently held by many administrators of hospitals since the early days of the mental hygiene movement, it is of interest to see whether it results in effective service for children. The Colorado program has been greatly curtailed in recent years because of financial difficulties, so our analysis will refer chiefly to the 1932 situation.

In contrast to the community service approach of the Boston Psychopathic Hospital the interests of the Colorado Psychopathic Hospital are statewide. The main function of the hospital is conceived in terms of "treatment of remediable types of mental disease, observation, research, and teaching"¹⁷ but to that is added a broad educational objective,¹⁸ which is furthered largely by means of a traveling clinic program and the education of medical students and practitioners. It was the aim of the director in 1931 eventually to help all the communities of the state to have clinical services and to foster the establishment of small psychopathic units in general hospitals. The assumption of such wide functions by a psychopathic hospital is probably traceable in part to the educational and administrative affiliations of the Colorado institution. The Psychopathic Hospital is a part of the University of Colorado and under the direct supervision of the dean of the School of Medicine and Hospitals. It is coordinate with the School of Medicine, the School of Nursing, and the Colorado General Hospital. As a part of a state university its interests include extension work as well as intramural teaching, and it necessarily has close connections with both educational and health programs throughout the state.

Interest in a psychopathic hospital first appeared about

¹⁷ *University of Colorado Bulletin*, Vol. XXXII, No. 7 (March 30, 1932), p. 21.

¹⁸ Franklin G. Ebaugh, "What Constitutes Fellowship Training in Psychiatry: Some Fundamentals," *Mental Hygiene*, Vol. XV (1931), p. 803.

1915, and four years later the state legislature authorized its establishment. Appropriations were delayed, however, and the hospital of eighty beds was not opened until the fall of 1923. Early in 1925 the outpatient department was set up. Its staff consisted of a chief of service (the director of the hospital), two psychiatrists, six assistant psychiatrists (fellows in training), a consulting pediatrician, a psychologist, and five social workers. Only one of the psychiatrists was employed full time in the clinic, the rest of the staff having hospital duties as well. The outpatient clinics were held four half-days a week, two being devoted to work with adults and two to work with children. About four thousand patients a year were examined, forty per cent being children.

The functions of the children's clinic were described as follows in the 1928-30 Biennial Report:

The children's clinic is designed to furnish facilities for examination of normal children with a view to improving their stability at home and in the community; facilities for the early detection and correction of personality characteristics and behavior disorders which might later lead to serious mental difficulties; facilities for the early detection and treatment of actual mental or nervous diseases; and facilities for the study and treatment of juvenile delinquency in children referred by the Juvenile Court and State Industrial School. Our object here is to attack mental illness at the source.

Two points in this description of services are of particular interest: that the clinic viewed its program as directed to the prevention of mental illness, and that it offered treatment as well as diagnosis. The first is the characteristic mental hospital point of view that has been commented upon in preceding chapters.

In the central clinic in Denver, the procedure at the time of our study was as follows. Six new cases were scheduled for each week, three fellows in psychiatry being assigned to this service to make physical and psychiatric examinations. The

physical examinations were made first and, if considered necessary by the psychiatrist, the children were referred to the psychologist for psychometric tests. Next the children were examined by the senior psychiatrist in the presence of the fellows, two physicians being assigned to each case, the senior to examine the child and the junior to take notes on the interviews. On the basis of this examination "mental status" was determined. Later in the week these and other children returned for psychiatric interviews with the doctors who made the physical examinations. Closed staff meetings of the physicians were held on the first day, and "cooperative case reviews," to which representatives of social agencies, the hospital social workers, the psychologist, and students in social work were invited, were held later in the week. Statistics showing the distribution of cases according to the number of visits they made to the clinics were not available but the average number of visits per case was 1.6 in the 1928-30 biennium.¹⁹

The Psychopathic Hospital initiated its rural work in the spring of 1925, when it joined the Child Welfare Bureau of the State Department of Public Instruction and the Extension Division of the University in conducting what were called community health conferences. These community health conferences provided for the examination of children and adults throughout the state by a group consisting of a public health nurse, dentist, optometrist, pediatrician, and gynecologist. To this staff the Psychopathic Hospital contributed a psychiatrist and a social worker. The director of the hospital attended some of the clinics in order to make contact with the county medical societies, and the examination

¹⁹ The Biennial Report shows a total of 1,502 child patients, of which 611 were new admissions. The total number of visits to the children's clinic for the two-year period was 2,326; the average number of children under treatment per week, 22, and the total under active treatment in the community at the time the report was written was 480.

of patients was conducted by the other psychiatrist on the hospital staff. The social worker interviewed the parents of children referred to the psychiatrist and gave psychological tests. During the three years of the hospital's participation in the program a hundred communities were visited and about fourteen hundred children were examined by the psychiatric group, this number representing about ten per cent of the total cases examined by other members of the community health conferences. About ten per cent of these children were found to be feebleminded and about fifty per cent were classified as showing "reactive behavior disorders."²⁰

The value of this type of mental health work was seen by the hospital staff as being chiefly educational, both for themselves and for the general public. Discussing their experience, they wrote:²¹

A mobile clinic has proved to be of great value in the educational program of the Colorado State Psychopathic Hospital. Through the mobile clinic actual contacts are made with the communities from which patients are referred to the hospital, a better understanding of the social forces at work in each community is made possible, and more accurate recommendations can be given at the time of discharging patients. The mobile clinic not only makes possible the examination of a large number of persons, many of whom are later referred to the hospital for treatment and observation, but is also a means of educating the community to an understanding of the purposes and functions of the hospital and the principles of mental hygiene. A mobile clinic should serve as a nucleus for a follow-up system and for the organization of mental hygiene clinics in the larger communities of the state. It should also pave the way for an active state society for mental hygiene.

²⁰ Calculated from figures cited for both adults and children in F. G. Ebaugh and G. S. Johnson, "A Brief Summary of the Activities of the Mobile Clinic of the State Psychopathic Hospital," *Colorado Medicine*, Vol. XXV, June 1928.

²¹ F. G. Ebaugh and R. Lloyd, "The Role of a Mobile Clinic in the Educational Program of a State Psychopathic Hospital," *Mental Hygiene*, Vol. XI (1927), p. 356.

In spite of the lack of resources for follow-up work in most communities, it was felt that the clinics were also of some value to the individual patients. The 1928 report of the hospital notes that on subsequent visits of the clinic group many children were found to be making a better adjustment. All the communities were said to have been very receptive to the work.²² Nevertheless it seemed to the staff that the attempt to examine a large number of patients in a short time made for work that was incomplete and of poor quality, so after three years they withdrew from the community health conferences.²³ Knowledge of the resources of the local communities, the incidence of mental hygiene problems, and the attitudes of local people gained from experience in the community health conferences, however, put the Psychopathic Hospital staff in a particularly favorable position to enter upon a more intensive extramural program. Requests for continuation of service came from the medical societies and social and health organizations of several counties, and the hospital entered upon a new program of what it called base clinics.

Between 1928 and 1932, five such clinics were established in towns ranging from 2,500 to 12,000 in population. These clinics accepted patients on a county-wide basis, but even that provision meant that no clinic served a population of more than 65,000. Since the kind of service the hospital could offer was presumably known to the communities through the community health conferences, responsibility for the initiation of a clinical program was left largely to the localities. An invitation from the county medical society was required, and the community had to assume the traveling and maintenance expenses of the unit. This amount has varied considerably from place to place, since one clinic met in a town fifty miles and

²² *Biennial Report of the Colorado Psychopathic Hospital, 1926-28*, Denver, University of Colorado, 1929, p. 46.

²³ F. G. Ebaugh, *op. cit.* (n. 18), p. 803.

another in a town 450 miles from Denver. The communities were also responsible for the physical and psychological examination of the patients and for furnishing the necessary stenographic assistance.

The initial contact with a community desiring clinic service was made by the director of the hospital or his assistant, and a series of lectures on the mental health of childhood—a unique feature of the Colorado program—was given to teachers and parents preceding or during the first year of the clinic's operation. This plan of procedure gave emphasis to the hospital's conception of the program as chiefly educational in nature. Therapeutic considerations were kept in the background, for the main objectives were that teachers, public health nurses (who are the chief source of social service in the rural areas), general medical practitioners, and hospital administrators should become acquainted with the mental hygiene point of view, and that psychiatric fellows in training should gain understanding of community problems.

The five communities in which clinics were conducted in 1932 received varying amounts of service. The two clinics in towns less than a hundred miles from Denver met monthly, the one 140 miles away met once in six weeks, and in the other two towns (250 and 450 miles away) there were sessions for two-day periods once or twice a year. In one town the school physician was especially interested in the clinics and did so much of the social work that generally only a psychiatrist went from the Psychopathic Hospital to that center. To the other towns the hospital supplied a psychiatrist, psychiatric fellow, and a social worker. Social histories of the patients to be referred to the clinics were generally secured by local workers—usually nurses—with some assistance from the hospital social worker, and the follow-up of the clinics' recommendations was also left to them.

Three clinics were held in schools, and the other two in

church buildings. Traveling and maintenance expenses of the staffs were paid for by the local boards of education in three towns, by the county commissioner in the fourth, and by the American Legion in the fifth community. Costs ranged from \$15 to \$125 per session, but the average cost per patient showed less variation, since in the distant clinics more patients were examined, the range being from four to twelve patients per day. Except in the San Luis Valley clinics, nearly five hundred miles from Denver, the average cost to the community per new patient was about three dollars. The total number of patients examined between 1928 and 1932 was 688, of whom eighty were adults. The cost of the base-clinic service to the state was approximately \$2,100 in 1931-32. This sum included the salary of a full-time social worker and the equivalent of 360 hours of psychiatric service.

Schools, health agencies, parents and relatives were the chief sources of the clinics' patients. Almost half of the 1932 cases came from the first source, the teachers tending to refer rather dull children who did not do adequate school work and those who showed rather obvious types of maladjustment, such as speech defects and marked nervous mannerisms. The I.Q. range among the total group of patients was wide, however, and less than thirty per cent were found to be subnormal. Recommendations for treatment included work with the parents as well as school and recreational changes and physical and psychological therapy.

Evaluations of the clinics' services by those familiar with the work tended to be much like those reported in other states. As usual, local people untrained in case work found it difficult to carry out recommendations concerned with changes in parents' attitudes, even though some assistance was given to them by the clinics' social worker. That worker herself seemed overburdened, since in most clinics she prepared cases for two psychiatrists. The association of the clinics with the

Psychopathic Hospital proved an obstacle in many cases, though from the hospital's point of view one of the chief objectives of the service was to "desensitize" the public and familiarize it with mental hospital work.

Another difficulty was reported to be the frequent change in psychiatric fellows. They were sometimes not accepted as experts by the local workers, and their orientation in community matters was an added responsibility for the single social worker. In spite of the fact that the county medical societies endorsed clinics, the number of patients referred by physicians declined each year, and the patients they did send to the clinics were chiefly feebleminded or neurological cases. Perhaps the use of relatively untrained fellows was one of the reasons for this lack of interest on the part of the local physicians, though that situation was by no means peculiar to Colorado.

On the other hand, the clinics seemed to have been very successful in meeting the communities at their own level of interest and in arousing in many nurses and teachers an interest in the mental hygiene aspects of their work. An important factor in this seemed to have been the personal characteristics of the staff members. They were greatly liked in the towns and seemed to have been successful in expressing their concepts in terms that had meaning for the lay public. Even with this favorable factor, however, the clinic programs prospered best in those towns in which the schools and public health organizations were originally favorably inclined toward the mental hygiene point of view and in which there were local workers who were energetic and cooperative. Lacking some such support, towns tended either to resist the whole movement as propaganda or to view it as a panacea. The community health conferences had served to avoid some of these difficulties (which, of course, were not confined to the Colorado program) by giving the workers some understanding of

the towns and their resources, and the towns some knowledge of what to expect from the clinics.

IOWA STATE PSYCHOPATHIC HOSPITAL

In spite of the fact that it was short-lived, the Iowa Psychopathic Hospital's program of "mobile and laboratory units" is of particular value to our study because it was set up as an experiment in rural service and the staff was composed of well-trained professional workers.²⁴ The program grew out of the interest of the director of the hospital, Dr. Samuel Orton, in disorders of reading, writing, and speech that he considered traceable, in part at least, to cerebral physiological causes. A mobile clinic, held in Greene County, Iowa, during 1925, yielded some interesting cases of this type, so the next year a grant from the Rockefeller Foundation was secured to enable the hospital to establish a clinic and laboratory for further research in this field. A "mobile unit," consisting of a psychiatrist, psychiatric social workers, and psychologists, was organized to hold mental hygiene clinics in various parts of the state in order to determine the need and feasibility of such a type of service, while a "laboratory unit" studied in detail the cases of reading, writing, and speech disorders that were found by the other unit. In other words, the project had a double objective—the rendering of general psychiatric service on a traveling clinic basis as a means of estimating need and interest on the part of rural communities, and research into particular types of disorders.

The mobile unit began work in February 1926, and continued its program for seventeen months. In the selection of communities from among those applying for the service, preference was given to those of a rural or semi-rural char-

²⁴ Much of the following material descriptive of the clinics was secured from the mimeographed "Report of the Research Program of the Mobile and Laboratory Units of the Iowa State Hospital Carried out under a Grant from the Rockefeller Foundation, January, 1926 to October, 1927."

acter in which the medical, legal, social, and educational agencies and authorities were interested in the experiment and willing to pay part of the clinic's expenses. The particularly interesting part of the plan from the point of view of our study was that the staff remained in each community for periods of time ranging from two to ten weeks, the usual length being six to eight. In all, twenty-six different communities were visited by the staff from eight main centers, the practice in county-wide services being to establish headquarters at the county seat and then hold clinics in the surrounding towns and consolidated schools. The amounts of money contributed locally toward the cost of the clinics varied from about \$150 to \$500 and usually covered from a third to a half of the expenses.

Another interesting feature of the clinics' procedures was that of organizing local committees, composed of representatives of various interested groups and of the general public. Preliminary meetings open to the public were held, at which the work of the clinics was explained, but otherwise no general publicity was attempted. The executive secretary and the psychiatric social worker of the mobile unit preceded the rest of the staff in the visits to the towns, made various preliminary arrangements, and conferred with schools and other referring parties as to the selection of cases for examination. The examination itself was of a threefold type. The social-psychiatric history was obtained by the clinic's social worker from parents, teachers, and other informants, the child was given various types of psychological tests by the psychologist, and the psychiatrist—with these data at hand—conducted the psychiatric examination. The collected data were reviewed by the whole staff, and recommendations were made by them to the referring parties. An interpretation of the findings was made to the parents in person whenever possible.

The chief source of referral of the 1,090 cases examined was the schools (63 per cent) and state orphanages (18 per cent), while the rest of the patients came from widely scattered sources. From a social-economic point of view it was clear that the patients represented a cross-section of the community, the majority of them coming from middle-class homes. Twelve per cent of the children were found to have superior intelligence, and thirty-six per cent were classified as borderline (70-79 I.Q.) or defective. The majority of referrals made by the schools concerned difficulties in learning; rather few children were reported to be involved in definitely anti-social behavior. Physicians, who displayed considerable interest in the clinics, were chiefly concerned about the causes of "backwardness" and nervousness in young children, although they did refer some cases in which they suspected nervous or mental disease. The clinics were used very little by the courts, in spite of the fact that the earlier experiment in Greene County had disclosed considerable interest on the part of the sheriff and the county attorney. It appeared to the clinical staff that unless clinics can be held coincident with court sessions there will be little demand for their services from the legal authorities of rural communities. As to the lay public, it was found that in spite of the lack of publicity about the clinics there were always some people who wanted to bring their children to the clinic for examination. The symptoms that aroused their interest were much the same as those the physicians reported. In addition, some parents of pre-school children wanted general advice about child training even though their children were showing no unusual difficulties. As the report of the experiment puts it, "Instead of encountering a prejudice against a 'mental clinic,' as might have been anticipated in the smaller communities, there were many more cases for whom examination was desired than could be

seen in the time allotted, and the number of such cases would undoubtedly increase if a permanent clinic were established or if such a service were available at regular intervals."

Other findings of this experimental program would appear to be also of importance for traveling clinic work in general. With regard to the education of the public, for instance, it was the conclusion of the staff workers that this was best confined to discussion of specific cases with the schools, agencies, and parents referring them. General parent education was left to persons particularly trained for that work (extension teachers from the university's child welfare research station) on the theory that it involves a different preparation and is in itself a full-time job.²⁵

Another finding was one that confirms much that was reported to our investigators. In spite of the fact that the environmental conditions of most of the clinic's patients were quite satisfactory from a social-economic point of view, recreational facilities fairly good, teachers personally interested in their pupils and willing to give extra time and help to them, school nurses and organized social service agencies available and cooperative, medical facilities good and physicians interested, it was found that serious difficulties were encountered in the treatment of definitely maladjusted children. The local social workers had such heavy case loads that they could not undertake the social treatment of families not already their clients, and the amount of psychiatric treatment the clinic could offer was definitely limited. The most satisfactory work was done, therefore, with parents of "excellent common sense . . . who were eager for suggestions for the better training of their children," and with schools in cases in which the clinic's interpretation of the social factors threw light on the children's intellectual problems. That the staff

²⁵ This and subsequent description of policy are from June Lyday, "The Place of a Mobile Clinic in a Rural Community," *Proceedings of the National Conference of Social Work*, 1927, p. 408-17.

could remain in a community for a longer time than is usual in traveling work was also found to be useful, particularly so because the staff thus became an intermediary between the schools and the homes and effected a "more cordial relationship between the two that persisted after the clinic's departure."

Further testimony to the value of longer-than-usual visits to a community was given by the experience of the clinic's psychologists. They found that it was necessary to know a great deal about the individual school system, the teaching methods used, and the personalities of the teachers before diagnoses of disabilities and recommendations for grade placement and the like could be made. Very favorable results in terms of arousing the interest of teachers and superintendents and effecting changes in administration and teaching methods were reported. In general, then, this experiment of the Iowa Psychopathic Hospital confirmed many of the findings of our survey. It indicated that even with a well-trained staff and a responsive community there are limitations to the kind of cases that can be effectively served, but that much valuable work can be done with children who are not extremely maladjusted but who are in need of understanding attention.

CHAPTER EIGHT

Clinics Conducted by Central Departments of State Governments

A THIRD source of state-financed psychiatric services for children is the state government itself. Through their central departments of mental disease, public welfare, health, or education a group of states offer clinic services to emotionally maladjusted children which supplement or replace the state hospitals' programs. Altogether twelve states at one time or another in the period 1930 to 1937 had some sort of centrally administered mental hygiene program outside the state hospital system. Some of these gave very little service, and long-lived or wide-scale activities were confined to five states. Massachusetts, New York, and Pennsylvania offered psychiatric clinics under the auspices of the mental health authorities (which in Pennsylvania belonged to the Department of Welfare and in the other two states were independent departments), and Illinois and California originally linked this work more closely with delinquency than with mental disease and so set up clinics in the departments that had charge of penal institutions.

As to other programs under central direction, the following are to be noted. The Connecticut State Department of Health has experimented with various plans; Maryland has conducted a few clinics under the joint supervision of the State Board of Mental Hygiene and the State Board of Health; and Indiana began in 1937 a small program under the auspices of the State Department of Health. In Virginia and Rhode Island the public welfare departments gave service chiefly to the state institutions and agencies; Nebraska has recently set up a clinic program under the State Department

of Welfare. One of the most recent developments is Michigan's Central Child Guidance Institute, set up by an act of the 1937 legislature to diagnose pre-delinquent cases, organize community agencies for treatment, and carry on an educational program on a community and professional basis. Delaware, too, might be included in the group of states with centrally directed psychiatric services, since its one state hospital is administered by the State Board of Charities, but its clinics seem more properly to belong to the group described in the preceding chapter. All of these services are too recent or too ephemeral to provide data for study at this time, interesting as some of them might be for this investigation.

It is rather difficult to generalize about the clinics of the five states with larger programs, since they exhibit so much diversity not only from one state to another but within the individual systems from time to time. Pennsylvania, for instance (which was one of the first states to undertake such work and whose clinics in 1932 examined over two thousand children), experimented with several arrangements and then abandoned most of its centrally supported services during the economic depression. The California and Illinois programs were also modified or reduced during those years, the first to an extent that almost annihilated it. New York and Massachusetts, on the other hand, continued their work with little change, the first with a wide program of numerous clinics (more than 4,000 children were examined in 1935) and the latter with efforts concentrated upon a few centers, to which was given a more intensive type of service.

In spite of these diversities, however, certain contrasts with the clinics conducted by the state hospitals are to be seen. Most obvious is the lessened emphasis upon mental disease. These clinics serve few, if any, adults and no patients on parole from mental hospitals. Usually not being manned by state hospital staff and proceeding from headquarters other

than those institutions, they possibly do not carry to their patients quite as much implication of impending psychosis. It is not likely that they are free of all such connotations, however, for many of them are used chiefly for securing intelligence quotient ratings of children suspected of being feebleminded and for diagnoses as to other causes of extreme maladjustment to school situations. Many of the clinics, on the other hand, stress their desire to study the child guidance type of patient and do a considerable amount of educational work in that area. Then, too, the staffs of these state-directed clinics, as contrasted with the state hospital ones, are apt to be more specifically trained for child guidance work and to devote their whole time to clinic activities rather than being—as in most state hospitals—trained primarily for work with psychotic adults and in hospital administration.

Administratively, also, the programs under these two types of sponsors differ. The clinics under central direction usually serve wider areas and accordingly tend to make fewer visits to each community. They are, therefore, usually forced to have a more formal plan of local organization (consisting usually of specified representatives, supervised history-taking, and written reports) and to rely to a greater extent upon local workers for carrying out their recommendations. Not that the state hospital clinics usually offer treatment beyond the initial examination (a previous chapter has indicated how rare such service is) or that the centrally directed clinics are necessarily purely diagnostic; we would merely point out that with wider areas to cover and less frequent clinic sessions the difficulties of offering treatment service are enhanced.

The main problem of the state hospital clinics, it has been suggested, is that of providing psychiatrists and, to a lesser extent, case workers who are adequately equipped to give help, directly or indirectly, to children who suffer from behavior disabilities other than those purely organic or intel-

lectual in nature. A second handicap to their work was found to lie in the connotation that the mental hospital holds for the general public. It would seem that both of these difficulties could be overcome to some extent by clinics that are centrally administered. In such clinics, however, other difficulties arise. The chief of these is usually stated as the danger of stifling local initiative, and much emphasis in the clinics' policy is placed upon stimulating the communities to develop services of their own.

As to objectives of state-directed activities, they are described as either that of stimulating the mental hospitals to enlarge their services or of providing the local communities with examples of child guidance work, whose financial support it is hoped they will eventually assume in whole or in part. With greater or less emphasis the administrators of the programs in the five states under consideration say that they wish to avoid paternalism and encourage local initiative, that they are furnishing demonstrations of a kind of work that should be carried on under other auspices, that their work is primarily educational in nature. Deliberately, then, there is no attempt at complete state coverage. The central departments will demonstrate a method in areas that hold some prospect of eventually assuming this work themselves; they will supplement already existing services; at most they will plan to continue their work in rural sections if the conditions are favorable but the possibility of local financing slight; but no state has accepted the continuous provision of facilities for the psychiatric study and treatment of children as the responsibility of the central government.

The laws by which the duties of the departments that conduct the clinics are defined might not necessitate such policies. This would seem to be particularly true of New York, Pennsylvania, and Massachusetts, whose mental hygiene divisions are legally authorized to enter into activities looking to the

prevention and treatment of mental disease and defect. In Illinois and California, on the other hand, the legal emphasis is upon the prevention of delinquency, the power to conduct clinics being granted as a means to research and education. In those two states the traveling clinic program originated in governmental surveys of problem children, both of which concluded that state assistance was needed to stimulate and supplement local efforts to identify and treat the children. By all five states, however, it is recognized that rural areas are not financially able to provide psychiatric services for children, and there is some question whether the amount of work to be done in counties of sparsely populated states would be sufficient to occupy the time of a clinic unit even if there were no financial handicaps to such a plan.

There is, accordingly, a wavering quality about the expressed or implied policies of the clinics under state administration. On the one hand, there are vigorous statements that the state intends to provide psychiatric services only temporarily, until the communities or the state hospitals will take them over; the communities must show that they want the clinics by—in some states—contributing to their financial support and, eventually, by providing some of the clinical service themselves. On the other hand, it is sometimes officially stated—and more frequently testified to by practice—that small towns cannot (or will not) supply the requisite facilities and that it is the duty of the state government, in the interest of reducing the number of its institutional charges, to provide the means by which mental disease and delinquency may be diminished.

So stated, the issue appears to be the familiar one of local versus state responsibility and, since the tendency in public welfare for several centuries has been toward expanding the base of financial support, it might seem that the weight of authority would be with those who would have the state as-

sume more and more of the cost. With psychiatric clinics, however, there is more at issue than the question of finances. The success of such work is dependent upon the understanding and cooperation of a large group of people who provide, by their attitudes and the facilities of their institutions, some of the means by which the clinics' recommendations are made effective. The crucial question for the centrally administered clinics, then, is how to secure adequate local participation in their programs. Policies of going only to the communities to which they are invited, of requiring communities to provide certain facilities and to pay the staffs' maintenance expenses, of surveying the local resources before entering upon clinic activities, even the repeated declarations that the clinics are only for education and demonstration can be regarded as merely different ways of expressing this same thing: will the communities cooperate, can they be led to cooperate in the work with problem children? By comparison, the question of who is to pay for the service seems of minor significance. The state governments might assume the whole cost of clinics, but how those clinics could be integrated into the work of the other local social and educational agencies would still require consideration. Our survey does not provide an adequate answer to that question, but by bringing to light some achievements and difficulties of several of the states' programs it may serve to sharpen some of the associated issues.

The following case studies of the programs of the five states that have had the longest histories are presented as illustrations of the ways central departments have provided psychiatric service for children and of the problems that accompany that endeavor. As in the previous descriptions, it is not our aim to bring the accounts up to date (for the economic depression has seriously handicapped some of the programs, and most of them are continually being modified), but we present them rather as case illustrations of what happens

when clinic theories meet the test of application to specific situations.

NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE

The history of the child guidance clinics now conducted by the Division of Prevention of the New York State Department of Mental Hygiene goes back to 1918, when the New York State Commission for Mental Defectives was established. Among the prescribed functions of that Commission was the promotion of "mental clinics." The first clinics were modeled after those of the state hospitals, already in existence for some years, and were held jointly with them in general hospitals, welfare centers, and school buildings. The Commission supplemented the state hospital clinic staff of psychiatrist and nurse or social worker by another psychiatrist and a psychologist, and all cases of suspected mental deficiency were referred to these examiners.

The first annual report of the Commission for Mental Defectives touches upon three aspects of clinical work that still, twenty years later, are reiterated in most discussions of the subject. There is, first of all, the question of reaching all the children who need help. The Commission saw itself as providing a service that was needed by at least six state agencies (the State Hospital Commission, the State Commission for the Feeble-minded, the Department of Education, the courts and penal institutions, and the charitable institutions under the supervision of the State Board of Charities and the Department of Health), and to that end the Commission attempted to create "such a system as shall result in the establishment of one clinic in each neighborhood and which shall answer the full needs of all individuals and all institutions in that area."¹ Then the Commission recognized that its patients

¹ *Report of the New York State Commission for the Feeble-minded, 1918-19, P. 5.*

could not be confined to the feeble-minded alone. "Besides cases presenting problems resulting in retardation, there will be seen nervous children who are often handicapped simply by the faulty routine or poor hygiene surroundings as instituted by ignorant parents and also behavior disturbances resulting from temperamental defects." Finally, it saw that its work necessitated local assistance, preferably from psychiatric social workers. "These workers," the writers of the report say, "are needed for purposes of investigation of the family and personal history and the home environment of those coming to the clinics, for instituting and conducting a continuous parole supervision of mental defectives in homes and colonies, for assisting in obtaining employment for those qualified, for bringing cases of alleged mental deficiency to the attention of the clinic and for assisting in making psychometric examinations at the clinics." In the years that have passed since that report was written, conceptions as to the causes of behavior disorders in children and the functions of a psychiatric social worker have somewhat altered, but the basic problems of statewide clinical service remain the three that are implied here: how to serve all sections and all agencies of the state; how to secure as patients children whose problems are not merely those of feeble-mindedness; how to provide the means by which the recommendations of the clinics can be made effective.

Later reports show that some progress toward the solution of these problems was made. The 1920 annual report comments that "further expansion of the clinics depends upon the more general public understanding as to the need for such facilities. . . . In time, clinics may be more and more regarded as local activities as the various communities become supplied with qualified workers. Certainly even now the problem of after-care and supervision may be largely made local by interesting existing social agencies and volunteer societies

in individual cases." Then, in 1924, the writers of the annual report said:

These clinics for mental defectives cannot confine themselves solely to the mentally defective child, nor is it desirable that they do so. . . . One sees in these clinics psychopathic types, the nervously unstable, children with physical defects and disease and glandular disturbances, the delinquent and many other types. The problems which they present are medical, social, and educational. It can be readily seen that these clinics therefore become clinics for the mental hygiene of children and for children's guidance.

In 1926 the report tells of expansion into rural sections by means of traveling clinics and the organization of clinics with the county rather than the state hospital as the unit. The cooperation of the private State Charities Aid Association was secured and follow-up work facilitated through the assistance of that organization's county agents. In the next year the State Commission for Mental Defectives was abolished and the work taken over by the newly organized State Department of Mental Hygiene.

The New York State Department of Mental Hygiene was set up with three divisions, concerned with, respectively, mental disease, mental defect and epilepsy, and prevention. At the head of each was an assistant commissioner.² Preventive work, says an informational pamphlet issued in 1929, was carried on "with the hope of checking the increase of patients in state institutions and of lightening the burden of the people of the state." To this end two types of clinics are offered—"state hospital clinics, devoted to persons suffering from nervous or mental disease and to those on parole from state hospitals, and child guidance clinics, conducted for the examination and treatment of problem children." The former,

² Recent changes in the law have modified this form of organization; the duties of the three assistant commissioners have been made less distinctive and each carries some share of the work of the three divisions.

which include child guidance as well as parole clinics, are conducted by the hospitals and have been included in a previous chapter.

For the purpose of providing services directly through the Department of Mental Hygiene the state is roughly divided into five districts, and to each a unit is supplied. This staff customarily consists of a psychiatrist, a psychologist, and a social worker, all full-time workers. The Department follows a deliberately passive policy in regard to opening clinic centers. It does not enter into promotional efforts or choose communities for development of facilities, but instead supplies its services to almost any community that requests it, regardless of whether or not its attitude toward the care of children and facilities for such care are all that might be desired. Each county has a "children's agent," who, under the direction of the State Charities Aid Association, supervises children in foster homes and those for whom adoption is being considered. And most schools have nurses and district supervisors. It is these people who, together with school superintendents, physicians, and public health nurses, become the "local agents" of the clinics and by whom is assumed the task of making appointments, preparing histories, and attempting to carry out the clinics' recommendations in individual cases. Such being the case, it is obvious that the work of the clinics varies greatly from place to place, both in terms of types of patients brought to them and effectiveness of the follow-up treatment.

When a new community asks for the services of the Department it is customary for a member of the field staff to visit it to discuss plans. No formal survey of community facilities is made, however, for all that is required of a local group is that they provide quarters for the clinic's meetings and histories of the children whom they wish to have examined. Since many requests come from schools, these require-

ments are fairly easily met, although the amount of time required of the school nurse for history-taking and follow-up sometimes makes for difficulties. For the most part, arrangements are made for regular visits to the town or school by the clinic staff, but in some remote localities they visit only on request, perhaps once or twice a year. It is recognized by the Department that such a policy results in unsatisfactory work in communities in which resources are meager and mental hygiene ill understood, but the policy has been deliberately maintained, with community education as its aim.

The results of these policies, in so far as the attainment of the objective of providing psychiatric services to all the sections and agencies of the state is concerned, are partially indicated by a steady growth in clinic centers and clientèle. In 1935 clinics were held at regular intervals in forty-nine centers and "occasionally" in forty more. Referrals to them increased from 619 in the first year of the Commission for Mental Defectives' work to about 4,500 in recent years. This latter number includes the children examined by the child guidance clinics of the state hospitals, such cases constituting about fifteen per cent of the total during the 1930's.⁸ Since these clinics (included in Chapter V) are indirectly under the supervision of the Department of Mental Hygiene, an estimate of the extent of state coverage achieved to date must take them into account. Table VIII shows the proportion of towns of various sizes in which the child guidance clinics meet.

It has been the policy of the Department to concentrate its attention upon the smaller communities, since large cities have other sources of child guidance services. As Table VIII shows, forty-three per cent of the clinics were held in towns of 10,000 population or less, and only sixteen per cent met in cities of over 50,000. On the other hand, state-financed

⁸ 1932, 13 per cent; 1935, 17 per cent, for example.

clinics were held in almost all the cities of over 25,000 population, including thirteen in New York City. The extent to which the clinics met rural needs is obviously impossible to estimate, but it will be noted in Table VIII that the propor-

TABLE VIII

Distribution of clinics accepting children as patients (New York State Department of Mental Hygiene, 1935) according to size of town; also number and population of incorporated towns, 1930

Size of Town	Number of Clinics			Incorporated Towns 1930	
	State Hospitals	Division of Pre- vention*	Total	Number	Population
Under 1,000	16	2	18	254	2,066,000†
1,000- 2,500	5	4	9	146	
2,501- 5,000	7	11	18	85	309,000
5,001- 10,000	9	7	16	41	278,000
10,001- 25,000	26	18	44	47	730,000
25,001- 50,000	11	3	14	11	800,000
50,001-100,000	5	3	8	5	
Over 100,000	13	1	14	7	8,405,000
Total	92	49	141	596	12,588,000

* Clinics scheduled at least one month in advance. In addition there were 40 "occasional" clinics. Data from National Committee for Mental Hygiene *Directory of Psychiatric Clinics, 1935*.

† This figure includes the population of incorporated towns under 2,500 (364,000) and that of unincorporated towns and rural areas (1,702,000).

tion of clinics to population was largest in towns of 10,000 to 25,000 and that proportionately very few clinics were held in the largest cities and in the rural areas.

The Department's general plan is to work slowly and to follow a community's own pace. Just as clinical service is established only at the request of a community or one of its institutions, so advertisement and educational work through announcements, lectures, case conferences, and the like are not greatly stressed. Recommendations for treatment, also, are adapted to the community's resources and mental hygiene

perspective, and reliance is placed almost wholly upon "manipulative" measures, such as change of school grade or program of studies, foster-home placement, treatment of physical disabilities, and the like. Discussion of a child's difficulties with his parents is sometimes advised, but little emphasis is put upon therapeutic work with parents themselves.

Except for the examinations and recommendations of the staff, the work of the clinics is carried largely by the local agents. In a few centers near to headquarters the clinics' social workers themselves retain a few cases for treatment but, for the most part, their work consists of supplementing histories by interviewing the parents when they come to the clinic and discussing the findings of the examiners with the persons who refer the children for study. The majority of local agents are school nurses or county children's agents, while in some localities this work is undertaken by the public health nurse, the school physician, or the school superintendent. Aside from the county children's agents, social workers are rare in rural New York communities. The local agents arrange the clinics' schedules and prepare the social histories of the children who are to be examined, unless the referring agency submits its own report. In cases not referred by social agencies, the local agents visit the homes, discuss the children's problems with the parents, collect some data about the children and their family situations, and urge the parents to come to the clinic with the children. If the parents comply, they as well as the children have interviews with the psychiatrist. The work of carrying out the recommendations is left in local hands. The clinics' reports go to the local agents, who discuss the findings with the appropriate persons, the usual policy being, however, not to give to others the verbatim reports.

With the second problem that confronts most mental hygiene programs—how to stimulate the referral of children whose problems are other than mental or neurological defect

—the New York State Department of Mental Hygiene seems to have made progress. In 1922, for instance, twenty-one per cent of the children referred to the clinics had an intelligence quotient of 90 or above, while by 1936 this proportion had been raised to thirty-three per cent. In the latter year, thirty-one per cent of the cases were classified as “primary behavior disorders,” as compared with twelve per cent in 1933, and a decline from fifty-three to thirty-seven per cent in cases of “simple mental deficiency or retardation” occurred.⁴

Our investigators found that there was a tendency in many centers to use the clinics largely for psychometric testing. Some school superintendents reported that they used the clinics as impartial examiners of intelligence in questionable cases and that the clinics’ findings were more readily accepted by parents because of the staffs’ remoteness from local prejudices. On the other hand, some school superintendents definitely deplored the association of clinics with mental deficiency and tried to avoid the danger of that stigma by referring to the clinics children of clearly adequate intelligence, concerning whose other difficulties they wanted advice. The county children’s agents, especially those who acted as the local agents of the clinics, usually brought to the clinics children for whom placement or adoption was being considered, some of them wanting clinic examination of all such children. While the court tended to use the clinics chiefly for psychological ratings or for diagnosis in extreme cases, social agencies referred chiefly children with behavior or personality problems. Other referral sources were found to be few, and their referrals were of various types. Private physicians very infrequently sent patients to the clinics for examination. In some communities a slight but growing tendency for parents

⁴ *Annual Report of the New York State Department of Mental Hygiene, 1931-32, 1935-36.*

to seek the clinics of their own accord was reported. If such trends in types of patients and referral sources testify to community education in mental hygiene, it would seem that the Department's policy of acceptance of communities at their own point of interest and desire has been somewhat justified by results.

Our survey, made in 1932, revealed that the clinics were enthusiastically received by most communities, in so far as this could be judged by the reports of school officials and other local agents. These people found the clinics' help indispensable and had few criticisms to offer. They varied in their opinions as to what kinds of cases they thought suitable for referral to the clinics, but they were almost unanimous in finding the clinics' recommendations practical and useful. Many schools looked on the clinics as the state's rightful contribution of specialized service (particularly mental testing) that they needed but could not themselves afford to maintain. They were in general agreement that the Department of Mental Hygiene was the appropriate agency through which such service should be given. When asked about the possibility of the local communities gradually taking over the work of the clinics, they said they were very doubtful, thinking the service too expensive for an authority other than the state to support.

In spite of the satisfaction with the work of the clinics, certain difficulties were revealed that are of general importance. It has been one of the basic convictions of the Department of Mental Hygiene that diagnosis without treatment is useless, and it is around the dilemma of how to provide adequate follow-up of recommendations in small communities lacking in case work agencies that most trouble centers. The clinics, it appeared, had been unusually fortunate in the character of their local agents. Nurses, school physicians, county agents

have given much time to clinic work outside of the normal requirements of their jobs, and have displayed unusual ingenuity and resourcefulness in interpreting the findings of the clinics to the appropriate individuals. But considerable dissatisfaction was reported by them regarding the amount of time and skill required. To gather material for a social history takes at least a half-day per case, they said; and adequate follow-up, even when confined to the teachers and principal alone, is apt to take at least another day. Many said frankly that work with parents is beyond their capacity. The few local agents who were case workers and some others who knew the communities well or were specially skilled in work of this nature were able to use the recommendations regarding parents, but most local agents said they could do little in this area.⁵ On the other hand, it was found in some communities that the child welfare agents were more adequately trained in case work than were the clinics' social workers, so that the plan of having the latter supervise them was sometimes resented.

These objections were more frequently expressed with respect to patients who presented typical child guidance problems than with respect to those who were mentally deficient or otherwise maladjusted in school. So far the difficulties have apparently not become acute, and it may be that the group of children who can be aided by methods other than case work with parents will remain so large that a clear-cut recognition of the issue can be avoided. It would appear, however, that some method of offering assistance to parents must be devised if, with a case load changing in the character of its needs, the clinics are to maintain their present reputation.

⁵ This difficulty in having recommendations regarding parents' attitudes carried out was noted in 1929 by V. C. Branham, "Analysis of 1,671 Cases Brought to the Child Guidance Clinics of the New York State Department of Mental Hygiene," *Psychiatric Quarterly*, Vol. III (1929), p. 580.

PENNSYLVANIA BUREAU OF MENTAL HEALTH

The mental health program of the State of Pennsylvania is similar to that of New York in several respects, perhaps because its director and chief field representative were earlier associated with the New York Commission for Mental Defectives. More explicitly than New York, however, it seeks to supplement and to coordinate the activities of the clinics conducted by the mental hospitals of the state and hopes that eventually its direct services will be needed only in rural areas, remote from state hospital centers. Like New York, its policy in regard to establishing clinics is flexible and makes few demands upon the local communities with regard to prerequisites or types of patients. With respect to staff, patients, and services rendered, however, there are some differences that provide instructive material for this analysis of the ways in which states meet the mental health needs of their citizens. The data on which our conclusions are based refer almost wholly to the situation in 1932, for recently the program has been so curtailed as to make further analysis uninformative from our point of view.

In the development of mental hygiene clinics in Pennsylvania a private organization, the Public Charities Association, played an important role. This association (formed in 1913 to carry on an educational and legislative program looking to the prevention of mental disease and defect, delinquency, and dependency) conducted surveys of the mentally ill and the mentally defective, set up several mental health clinics for demonstration purposes, and in 1921 framed and urged the passage of a legislative act creating a State Department of Welfare. One of that Department's four divisions is the Bureau of Mental Health, which has as its function the "application of the laws relating to mental patients of all kinds . . . ; the coordination of activities in behalf of such patients; the stimulation of high standards of treatment and care of

mental patients; the promotion of activities in the interest of research and education . . . ; and, last, the important function of the establishment of measures and activities for the prevention of mental disease and defect."⁶

Under the latter assignment of duties, the director of the Bureau began in 1922 to set up a traveling clinic program and to provide the existing clinics of the state hospitals (at that time seven in number, conducted by three hospitals) with psychological service. Difficulties centering around state supervision and the relative positions of psychiatrists and psychologists in the clinics developed in two hospitals, and after a few years the plan of joint work there was given up.

In the meantime the Bureau of Mental Hygiene went ahead with its plans of establishing clinics in towns that were not served by the hospitals, fifteen being organized within the first year. By 1932, when our survey was made, there were forty-four active clinics, which in that year examined 2,071 patients.⁷ The clinics operated on a county-wide basis, except that in five counties two clinics were held. Altogether, the Bureau was giving clinic service to thirty-nine of the state's sixty-seven counties, six of the forty-four clinics being held in towns of less than 50,000 population and fifteen of them in towns of less than 10,000. The localities in which clinics were held were districted, and each was served by a unit consisting of a psychiatrist and a psychologist. The clinics met from one to eleven times during 1932, the average number of meetings being six per community. Six to eight patients were examined at each meeting. At the present time (1939) much of this work has been abandoned because of the economic depression, and the provision of clinics has been left largely to the state hospitals.

⁶ William C. Sandy, "The Activities of the Bureau of Mental Health," *Mental Health Bulletin*, Pennsylvania Department of Welfare, Vol. VI (1928), p. 3.

⁷ During the same year the state hospital clinics examined 1,175 patients.

The fact that the clinics were originally established for the "early identification, study, advice, and supervision of mental defectives" had a marked influence on the Pennsylvania program. The director and his chief assistant, a psychologist, it has already been noted, came from the New York Commission for Mental Defectives. The "field representatives" were psychologists, who combined psychometric testing with the usual duties of traveling clinic social workers and were also responsible for the supervision of mental defectives in the community. A large proportion of the patients have been persons of low intelligence, many of whom were brought to the clinics with a view to institutional placement. Nevertheless, the clinics made an effort to secure other types of referrals. A bulletin issued in 1925, for example, stressed the fact that "there are many instances of disordered conduct in children which have nothing to do with either mental defect or physical disease" and noted that "the cause of such deficiency in school progress or troublesome behavior eludes detection unless accurate knowledge of the home situation and the child's reaction to the various members of the family, the child's individual desires, special abilities and interests and his repressed emotional complexes is obtained."⁸ The clinics' staffs were designed to include psychiatrists as well as psychologists, and an effort was made to secure for the latter positions individuals who had had some training in social work.

With regard to psychiatrists, the Pennsylvania clinics were like those of California in that they utilized for this work members of the staffs of state hospitals and schools for the feebleminded, using the Bureau's own "field psychiatrists" only in towns in which the services of the others were not

⁸ *Mental Health Clinics*, Bulletin 24, November 1925, Pennsylvania Department of Welfare, Bureau of Mental Health, p. 2-3.

available. The number of such field psychiatrists on the staff has varied, consisting in 1928 of one full-time and two part-time physicians and in 1932 of one full-time and one part-time worker. None of them had had much training in child psychiatry. These field psychiatrists served eighteen of the forty-four clinics operating in 1932; psychiatric consultation for the remaining clinics was supplied by one county and four state hospitals, by a school for the feebleminded, and by two local institutions. Few comments about the character of the psychiatric work of the clinics were elicited during our survey (a fact that may be related to the character of the referrals as well as to the quality of the work), but one consultant psychiatrist himself deplored the paucity of other than mentally defective patients and said that more time should be allotted for conferences with the local social workers.

The psychologists on the clinics' staffs—four in number in 1932—were called field representatives. Their minimum training included a master's degree in psychology and some training or experience in social work. To them was delegated the responsibility of organizing and setting up the clinics, and they acted as the clinic managers. At one time they did some of the work connected with carrying out the clinics' recommendations in cases in which no other social agency was available, remaining in the community for that purpose for one day after the clinical sessions. Later, pressure of work necessitated the abandonment of that plan. In addition, the field representatives on request gave psychometric tests to children in towns which had no clinics (there were 378 such cases in 1932) and investigated all applications to the state schools for mental defectives. They supervised, either directly or through reports from social agencies, the care of all mentally defective children who were not committed to state schools, and they took the initiative in what has been de-

scribed as "cleaning out the 'foci of mental defect' " by breaking up feebleminded families, particularly in isolated districts.⁹

In setting up a clinic, little was required of a community other than that it provide adequate quarters (usually in a hospital, courthouse, or social agency office) and social histories of the patients who were to be examined. Most of the clinics grew out of special psychological services given by the field representatives to local agencies, which after a time requested periodical visits. The approval of the county medical society was usually secured by the Director of the Bureau of Mental Health, and the field representative made an informal survey of local opinion, but clinics were frequently established without the unanimous approval of the various local groups. Altogether, the procedure was very informal, there was little standardization of policy or procedure, and for years the units functioned rather independently. Later, there was some attempt at formulating more definite policies in the central office, and some uniform regulations for appointments and record keeping were devised.

Originally, local secretaries were appointed for each clinic center, their duties being to make appointments and see that the case histories were in order by the time the clinic staff arrived. Later this was given up, and it was required that requests for appointments be sent directly to the Bureau headquarters, and the social histories and all case records were filed there. This change of plan created considerable resentment locally, and in some clinics it was said that referrals fell off. The Bureau, however, justified the policy as follows. They found that the requirement of sending the social histories in advance of a clinic's meeting improved the quality

⁹ This description of the work of the field representatives is taken from Florentine Hackbush, "Mental Clinics and Other Field Activities," *Mental Health Bulletin*, Pennsylvania Department of Welfare, Vol. VI, No. 3 (October 1928), p. 6-9.

of the material submitted and enabled the staff sometimes to make recommendations without examining the patients, thus facilitating treatment in emergencies. Centralized appointment schedules were a necessary part of this arrangement. As to the removing of the case records from the local centers, it was felt that secrecy was more easily maintained, that costs were reduced, and that the information in them was more frequently needed at headquarters than in the local offices.

The clinics exercised little control over the types of cases referred to them. Both adults and children were accepted but about eighty per cent of the patients were under nineteen years of age. No statistics in regard to the types of problems they presented are available, and those of I.Q. ratings include both mental hospital and Bureau clinics. The combined figures show that in 1931-32 about a third of the patients had an I.Q. above 80, and eighteen per cent had ratings of 90 or higher. The clinics were used by a wide variety of agencies. In 1931-32 almost half of the patients were referred by family and child welfare agencies and institutions; the schools were the source of about seventeen per cent, the courts of eleven per cent, and health agencies of nine per cent of the cases. The service given by the clinics consisted chiefly of diagnosis and recommendations for institutionalization or for supervision in the community. Reports of the examiners' findings were mailed to the referring agencies within a week after a clinic's meeting. There was little attempt at education of the local agencies, although in a few centers the holding of two-hour staff meetings open to agency workers was well received.

Advantages and disadvantages to this mode of operation of clinics were found by our survey workers. It seemed that the frank concentration on problems of mental defect and obvious neurological conditions resulted in more satisfaction with the clinics' work than was found in some other states

which put more emphasis upon child guidance types of cases and services. In this respect the situation was much like that earlier described in state hospital clinics, and the Pennsylvania Bureau of Mental Health clinics did have much in common with the state hospital type of work, especially in that they secured much of their psychiatric assistance from the hospitals. In spite of its industrial development and its several large cities, Pennsylvania is essentially a rural state, half of its counties having a population density of less than one hundred inhabitants per square mile. Outside of the large centers trained social workers were few, and interest in the mental hygiene field centered chiefly about problems of extreme maladjustment. To a considerable degree, then, the Bureau of Mental Health appeared to be meeting the outstanding needs as the counties saw them. On the other hand, since Pennsylvania has a long tradition of interest in psychiatric matters, and some of its case workers are leaders in the application of psychiatry to social work, it did not surprise our investigators to find in some quarters much dissatisfaction with the work of the Bureau, and to learn that in several medium-sized cities movements were under way to set up local child guidance clinics modeled after those of Philadelphia and Pittsburgh.¹⁰

As to the details of clinic policy, various comments were made by the staff members themselves that give some indication how they worked in practice. It was said that the clinics needed better trained personnel. The psychologists were well equipped for psychometric testing, but some of them felt handicapped by their lack of case work training. The use of local psychiatric consultants was said to be sometimes disadvantageous, any question of replacement being apt to cause unusual difficulty under this plan. Referrals were said to be sometimes too numerous and case histories inadequate. One

¹⁰ Such a clinic was established in Reading in 1936.

psychiatrist maintained that the policy of giving the communities free rein in selecting cases for referral resulted in unnecessary examinations, and a psychologist felt that much of the work might better be carried by psychiatric social workers. Several informants deplored the lack of community organization and education, saying that the work of the clinics was repetitive and that little advance in community resources was being made, but others claimed that the instituting of special classes in some schools was partly traceable to the clinics' work. The need for some means of carrying on psychiatric or at least case work treatment of a certain proportion of the patients was frequently stressed, and the suggestion was made that local community chests be stimulated to employ psychiatric social workers for that purpose. For the most part, then, the merits and faults of the clinics were found to be the same as those reported in regard to other organizations in which the work is predominantly with mental defectives, and the conclusions to be derived from the survey of Pennsylvania seem to be essentially those stated in the previous chapters.

MASSACHUSETTS DIVISION OF MENTAL HYGIENE

The program of the Massachusetts Division of Mental Hygiene represents a very different approach to the problem of supplying psychiatric services to the children of the state, but it has at least one point in common with that of New York and Pennsylvania in that it seeks ultimately to transfer its work to the state hospitals. Aside from this, the programs have little in common. That of Massachusetts is largely urban and is confined to children of less than eight years of age. Its clinics provide treatment as well as diagnostic services. They are set up at the instigation of the central authority. They make no attempt at state coverage but are frank demonstrations in areas in which many supplementary social re-

sources are available. Differences such as these necessarily alter the whole picture and provide thereby an interesting contrast, particularly with respect to meeting treatment needs.

One clue to the reasons for the difference may be found in the law by which in 1922 the Division of Mental Hygiene in the State Department of Mental Diseases¹¹ was established. That law assigns to the Department of Mental Diseases the duty of taking "cognizance of all matters affecting the mental health of the citizens of the commonwealth," making "investigations and inquiries relating to all causes and conditions that tend to jeopardize said health," and "collecting and disseminating such information relating thereto as it considers proper." Duties "imposed upon the Department relating to the cause and prevention of mental disease, feeble-mindedness, epilepsy and other conditions of abnormal mentality" may be performed, as the Commissioner may determine, by the Division of Mental Hygiene, which may, in addition, "establish, foster, and develop outpatient clinics."¹² In the mandatory character of the research duties in contrast to the permissive nature of the Division's clinical work lies one explanation of the distinguishing characteristics of the Massachusetts program. Research has been stressed by the director and much of his own attention has been given to it. In the clinics themselves an attempt has been made to keep the work well within the hands of the staff so that its progress and difficulties may be noted, such practices as daily assembling at headquarters and weekly staff meetings being designed to foster this point of view. Narrowing the work to one particular age level and confining it to particular kinds of communities may give further evidence of a research attitude on the part of the administration. While to draw the distinction too rigidly is doubtless unjustified, there does seem to be some

¹¹ Name changed in 1938 to the Department of Mental Health.

¹² *The Massachusetts Laws Relating to Insane Persons and Other Classes under the Supervision of the Department of Mental Diseases*, Chap. 123, General Laws, Sec. 3A and Sec. 13A, pp. 5, 7.

basis for contrasting the Massachusetts program with that of New York in terms of research versus service. The two points of view supplement each other, of course: research is possible only through giving service, and service itself provides data for research; but emphasis upon one or the other may produce great differences in actual practices.

The clinic which served as a model for the Massachusetts habit clinics was already in existence when the Division of Mental Hygiene was set up, and its director was the person, Dr. Douglas A. Thom, who was chosen to head the Division. This original habit clinic was organized in 1921 by a group of Boston social agencies and met in a settlement house. Dr. Thom, its psychiatrist, spent a half-day a week in the clinic and was assisted by a case worker, who was employed for half-time service. The patients of the clinic were preschool children, and its objective was prevention of emotional disorders through early recognition of unfavorable habits and individualized parent education. The clinic was used chiefly by social agencies for consultation and treatment. Dr. Thom, on assuming the office of director of the Division of Mental Hygiene, took this habit clinic unofficially into the Division and within a year set up three other such clinics in other sections of Boston directly under the Division's auspices. By the end of 1931 fifteen more habit clinics had been established, some of them, however, having been discontinued by that time.¹³

In contrast to the New York state plan, by which clinics are initiated at the request of local communities, the Massachusetts policy has been to keep the planning largely within the Division's own hands. It decides, more or less independently, where clinics shall be opened and then secures the help of the state Society for Mental Hygiene in arousing local interest. The Society, working through its district advisory

¹³ The original habit clinic was soon separated from the others and has continued under private support, retaining Dr. Thom, however, as its director.

committees, takes charge of preliminary publicity and sends a member of its staff to secure local interest and support. Social agencies, schools, parent-teacher associations, and physicians are interviewed. Conferences of those immediately concerned are held, lectures are given to professional groups, and finally meetings open to the general public are held. The Society for Mental Hygiene makes the necessary arrangements for housing the clinic, and, when all is prepared, the staff arrives and makes its plans for carrying out the functions of the clinic.

By 1936 only one clinic had been set up in a city as far as a hundred miles from the clinic's headquarters in Boston, and the work of that clinic (in Springfield) was early taken over by the local social agencies and a nearby state hospital. The rest have been located in or near Boston, in residential or mill communities in which social agencies, hospitals, and schools can offer supplementary services of various kinds. Of the eighteen clinics in existence at one time or another, nine have been discontinued—some because the local response was not adequate (this situation occurring chiefly in districts of Boston in which a large proportion of the population were foreign-born) and two because the work was assumed by state hospitals. The ten that were in operation in 1936 were located in the following centers—Boston: West End, Boston Dispensary, New England Hospital, East Boston; Quincy, Norwood, Lawrence, Lowell, Reading, and North Reading Sanatorium. The last-mentioned is a clinic established experimentally in 1928 in a tuberculosis sanatorium and has met monthly ever since. The other clinics met weekly for three-hour sessions. Three clinics—Lawrence, Quincy, and Norwood—met at the same time and (two of them) in the same place as the child guidance clinics of the Danvers State Hospital. The others, still unconnected with services for older children, had general hospital relationships, several being closely connected with pediatrics departments.

In 1936 the staff of the clinics consisted of the director, who did little clinical work, and two full-time psychiatrists, five full-time psychiatric social workers, and one chief and three assistant psychologists, all of whom worked on a part-time basis. The psychiatrists, who, with the exception of the director, were women, had been trained in both pediatrics and child guidance, one of them having earlier been a social worker. The psychiatric social workers were graduates of professional schools of social work, while the assistant psychologists were doctoral candidates in local universities. These people assembled each morning in the clinic headquarters in the State House and went to the respective clinics from there.

In contrast to the usual plan of traveling clinic service, the Massachusetts habit clinics offer treatment as well as diagnosis and work in much the same manner as the privately supported urban child guidance clinics. The original plan of these clinics with respect to history-taking was like that of most traveling clinics, the most efficient procedure seeming to be that of securing data before a child was brought to the clinic center. In practice, however, this was found to have its drawbacks. Parents whose children were referred to the clinics by outside sources seemed puzzled, to say the least, by a visit from a social worker before the child was examined at the clinic, and unnecessary resentment was incurred in some cases. The policy was changed, therefore, to accord with that of most clinics; referring agencies submit summaries of the cases as they know them, and the parents are interviewed when they bring the children to the clinics. Physical, psychological, and psychiatric examinations of the children are made at that time, and plans for treatment are worked out in staff conferences.

In "full service" cases (which in 1936 constituted seventy-seven per cent of the total) treatment is carried by the clinical staff and consists of the usual combinations of case work and

psychological and psychiatric therapy, depending upon the clinic's decision as to the needs of the case. In certain cases the staff is assisted by a group of reading-disability tutors, who are provided by the Boston University Graduate School of Education. Outside aid is also given by numerous physicians, for the Division of Mental Hygiene has a policy of providing no services of this nature. This policy, undertaken to enlist the interest of local physicians and forestall possible antagonisms, has created difficulties in some centers with respect to fees. The clinics, being tax-supported, must give their services without charge. The clinics and the local physicians and hospitals have come into conflict about this matter only in the centers in which the patients' families are fairly well to do, and various devices for charging for the physical examinations have been tried out, none of them with complete success. On the whole, however, the administrators of the Division consider the policy successful, the interest in child guidance work aroused among physicians offsetting the other obstacles, in their opinion.

Partly because the state's provision of "school clinics" that give psychological and psychiatric examinations to all children three or more years retarded in school, the habit clinics have not been as frequently called upon for help with the feebleminded as are most state-sponsored clinics. For a time they considered refusing to accept children as patients whose intelligence quotients were under 75, but it was decided that such an elimination could not justifiably be made, since the school clinics have no treatment facilities. The present policy is to accept all cases for examination and to offer treatment if need for it is indicated, regardless of the child's intelligence. Most patients, however, are children of adequate intelligence, with difficulties of environmental or intra-psychic causation. Three-fourths of them in 1936 were of school age, but the great majority were under nine years old.

From two to six children are seen at each clinic session, the usual plan being to hold weekly meetings of three hours' duration. In 1936 the active case load of the clinics was 948, 666 being new cases. These figures were fairly representative of the annual case loads, the average annual intake for the five-year period, 1932-36, being 676 cases, and the average monthly case load, 341. Many children returned to the clinic for treatment subsequent to the initial examination, the average being about four visits per child.¹⁴ In addition, the case workers did some home visiting.

In recent years there has been considerable change in the proportion of cases coming from the various referral sources. Comparing 1930 with 1936, for example, we find that more children were being referred in 1936 by schools and health agencies and fewer by private physicians, relatives, and friends. School referrals made up eighteen per cent of the cases in 1930 and thirty-one per cent in 1936; health agencies sent to the clinics twenty-seven per cent of the cases in the former year and thirty-five per cent in the latter, while private referrals constituted forty-three per cent of the 1930 cases and twenty per cent of those of 1936.

For years the Division consistently viewed its clinic program as temporary, its aim being to stimulate the state hospitals to offer comprehensive mental health services to the districts in which they are located. Recently, however, there appears to be some doubt as to the feasibility of that plan. In his 1936 report the director says that the assumption of community activities by state hospitals is dependent upon the superintendents' interest and their ability to provide well-trained staffs for such work. He writes:

It has been demonstrated beyond all doubt that we cannot expect the state hospitals to operate these clinics with the by-prod-

¹⁴ Figures from *Annual Report of the Massachusetts Commissioner of Mental Diseases for the Year Ending November 30, 1936*.

State Department Clinics

ucts of their hospital staff. The needs of these clinics for children are not those of the institution, either in the interest, training, or experience of the personnel which make up the staff. If this type of service is to be rendered . . . it is absolutely necessary that each institution be provided with funds with which to secure adequately trained psychiatrists, psychologists, and social workers and that the clinic personnel should not have duties connected with the institution.¹⁵

It would appear, therefore, that the Massachusetts Division of Mental Hygiene has more or less renounced its earlier policy of providing clinics as temporary stimulants to state hospital endeavor in the field of child guidance or has at least recognized that work to that end is dependent upon something more than arousing enthusiasm among state hospital superintendents.

ILLINOIS INSTITUTE FOR JUVENILE RESEARCH
COMMUNITY CLINICS

The Illinois state plan of helping local communities to meet the mental hygiene needs of children differs in several important respects from those of New York and Massachusetts. One important distinction lies in its complete separation from the mental hospital program. The Illinois state hospitals offer almost no outpatient clinics for children, nor is it planned that they shall do so in the future. Instead, the state's contribution to local mental hygiene work is made under the auspices of the Illinois Institute for Juvenile Research, which maintains a large, well-equipped clinic in Chicago.¹⁶

Another distinguishing feature of the Illinois program is

¹⁵ *Ibid.*, p. 60.

¹⁶ This clinic is fairly comparable to the other urban ones described by Stevenson and Smith and so will not be included in this survey. For a detailed description of the services of the Institute for Juvenile Research see *Child Guidance Procedures*, written by the staff of the Institute and published by D. Appleton-Century Co., New York, 1937. Also, *Annual Report of the Illinois Department of Public Welfare*, 1936, p. 396-429.

its emphasis upon the child guidance type of patient. The traveling clinics—like those in Chicago—make a definite effort to secure the referral of children who suffer from behavior or personality maladjustments and who are of adequate intelligence. This policy, which resembles that of the Massachusetts habit clinics, is combined with that of giving only a diagnostic type of service and relying upon local agencies for treatment work. In addition, clinics are held in a community only at the request of the local people and after a survey of the community's resources, and the traveling expenses of the staff are borne by the local authorities. In other words, the program requires an assumption of more local responsibility than is the case in the states previously described, with the result that the clinic centers are usually fairly large towns. The long-time aim is that the towns shall develop their own clinic facilities, and to that end paternalism is deliberately avoided.

It seems clear that it is in these policies that the causes of the distinctive problems and achievements of the Illinois program are to be found. The interest in child guidance stimulates the referral of many children whose difficulties are due to emotional maladjustment, and responsibility for treatment rests largely with the local agencies. Clinics must therefore be established in towns with fairly well-developed case work facilities, but responsibility for clinic management must usually be assumed by one among several agencies. The following more detailed description of the work of the clinics may make the situation clearer, but the most general conclusion that can be drawn is that the Illinois program demands a kind of local participation that only a few communities have been able to give.

The beginnings of the Institute for Juvenile Research have been described in a previous chapter.¹⁷ It was established in

¹⁷ Chapter III.

1909 as a privately financed clinic (called the Juvenile Psychopathic Institute) attached to the Juvenile Court of Cook County. Its director was Dr. William Healy, and its objective the study and treatment of juvenile offenders. Five years later it was taken over by the county and made an official department of the court. In 1916, when the state government was reorganized, a state criminologist was appointed a member of the Department of Public Welfare, and the Juvenile Psychopathic Institute (later named the Institute for Juvenile Research) was put under his jurisdiction for the purpose of extending the work of the clinic to the state at large.

The interest of the Institute at first centered about delinquency, the state's interest in the welfare of its psychotic members being the charge of the state alienist. Delinquency was regarded by Healy, however, as having its roots in unhealthy social and familial situations and in mental conflicts and defects, and the Institute's program of prevention was therefore soon broadened to include children who were not yet—and perhaps never would be—delinquent. In 1916 such children were brought to the clinic largely by social agencies, but in the subsequent years the sources of referral as well as the types of patients grew more varied. By 1934 seventy-five per cent of the referrals were evenly divided among schools, relatives, and social agencies, while courts and health agencies or private physicians accounted for the rest.¹⁸

In the Institute's program are included a large variety of services. There is, over all, the large headquarters clinic with a staff composed in 1935 of the director and four psychiatrists, seven psychologists, one pediatrician, nine social workers, four recreation workers, and five sociologists, with many students in training in most of these fields. In addition, from

¹⁸ Staff of the Institute for Juvenile Research, *Child Guidance Procedures*, op. cit., p. 323. In 1916, 75 per cent of the cases came from social agencies, while in 1934 the percentages were as follows: court, 14; social agencies, 23; parents and other relatives, 25; schools, 27; health agencies, 9; physicians, 2.

time to time there have been varying numbers of research persons on the staff, some of whom have carried on therapeutic work. This clinic offers various types of service, ranging from full examination and treatment to single examinations in specified areas, the latter consisting chiefly of psychological tests for feeble-mindedness. The headquarters building houses a preschool clinic as well, in which a pediatrician combines the work of physician and psychiatrist. The Institute also maintains in Chicago a juvenile court clinic, at which children who are to be sent to correctional institutions may be examined, and two branch clinics, which were established in neighborhoods widely different in economic status in order that the influence of social factors might be observed. As a part of the Department of Public Welfare the Institute gives service to the state's wards—the mentally handicapped, delinquent, dependent, deaf, and blind children who are living in state institutions. Finally, it provides to certain towns and rural areas traveling clinics with staffs drawn from the headquarters' personnel. While these latter clinics constitute but a minor part of the Institute's services, it is with them that our discussion will be chiefly concerned, for they provide an interesting example of the possibility and difficulties of carrying on child guidance work through infrequent clinic sessions.

The traveling clinic of the Institute for Juvenile Research program started with a psychological survey of Freeport, Illinois, in 1917, the psychologist returning to the town periodically until 1923. This type of service was soon afterwards given to several other towns, but the most important impetus to the later traveling clinic work came from the Institute's experience in three towns in LaSalle County (LaSalle, Peru, and Oglesby) which had formed the Tri-Cities Family Welfare Association. This organization in 1920 requested the help of the Institute with certain of their especially perplexing cases, and to the town twice a year was sent

a clinical unit of psychiatrist and psychologist that examined children on referral from the agency. Three years later the Association, with the backing of the local school boards, the Chamber of Commerce, and several clubs, asked the Institute to make a survey of the mental health problems of the three towns.¹⁹ Psychometric tests were given to all the school children, and both children and adults who were considered mental health problems by schools or social agencies were studied by the psychiatrist and the social worker. This survey had important consequences for the state program. It showed the feasibility of sending the three-worker units into small communities. It established the precedent of sending clinics only at the united request of local agencies to which could be entrusted the work of carrying out the clinics' recommendations for treatment. And it aroused such interest in the state at large that a bill authorizing and financing a "state survey of specially handicapped children" was passed by the legislature in 1924.

This survey was considered necessary by the Department of Public Welfare because there was an "insistent demand from several quarters for a sufficient number of special institutions for the study of all subnormal children and children with special handicaps."²⁰ The Department doubted the necessity or wisdom of engaging upon such a program and proposed the study as a means of determining the extent and quality of the problem. Since much of the interest of the Department centered about mental deficiency, the survey introduced into the Institute's extramural program some deviation from its original interest in delinquency alone. Its findings also set other principles for the later work of the Institute's traveling clinics, its influence being especially great because

¹⁹ For a description of the work and findings of this survey, see Cornelia D. Hopkins, "The Mental Health Survey," *Mental Hygiene*, Vol. VIII (1924), p. 83-93.

²⁰ *Report of the Survey of Specially Handicapped Children in Illinois*, Illinois Department of Public Welfare, Chicago, 1925.

the financial backing for the clinics had come largely from the annual appropriations of the legislature to continue this "survey of the specially handicapped."

Among these principles were the following: that "centralization leads to unsound policy; decentralization is desirable if we wish to escape paternalism"; that "the program . . . shall secure the independent functioning of the local units of government and at the same time not deprive the people of the benefits of the state association to which they are entitled"; that "the local unit of government should supply a minimum of the machinery necessary for dealing with this problem, and the state should furnish a general consulting and supervisory service"; that "the first consideration should be the establishment of an initial sorting process" to discover which children can be benefited by special class training (with which the survey suggests all school systems should equip themselves) and which need institutionalization or other methods of treatment; that "the state will have to assume the responsibility for the efficiency of the sorting and advisory service," which should be headed up by the Institute of Juvenile Research through field units which "will be able to select those individual cases that really require special and intensive study." This emphasis upon the feeble-minded grew less as the Institute began to assert its point of view in the individual clinics that were set up after 1926, but the other characteristic features of the Illinois program remain much as they were stated in the survey's recommendations. In a recent annual report of the Department of Public Welfare, the criminologist defines the purpose of the community clinics as "the development of local community resources so that each community may be well equipped to meet its own problems of child guidance."²¹

When a community requests that a clinic be established,

²¹ *Annual Report of the Illinois Department of Public Welfare, June 1936, p. 419.*

the Institute sends a staff member to survey its resources and to ascertain the desires and the working relationships of its social agencies, courts, schools, and medical profession. If satisfied that the situation is one conducive to the development of child guidance, the Institute periodically sends to the community one of its clinic units, consisting of a psychiatrist, psychologist, and psychiatric social worker. These people are members of the Institute's central staff, all of whom are assigned some community clinic duties. The psychiatrists vary considerably in their experience, since the Institute serves as a center for inservice training, but the case workers and psychologists (though they may be assisted by students in training) are professionally well equipped for their work. The aim in sending a unit to a community is to supplement the local resources until the community is able to maintain its own study and treatment facilities. If, after some years, there is no evidence of growth in that direction, the Institute discontinues its service.²²

The conditions to be met by a community before services are given are the following:

1. Desire for the clinic on the part of the local physicians, school officials, court workers, and social agencies
2. A structure of social agencies which makes possible the preparation of social histories and the carrying out of the clinic's recommendations
3. Inter-agency harmony sufficient to favor the clinic's development
4. A local agent that will be responsible for history-taking and follow-up
5. Suitable headquarters for the clinic
6. Provision for the physical examination of the clinic's patients
7. Stenographic service, as needed
8. Funds to cover the clinic's traveling and maintenance expenses

²² Ibid.

Several of these conditions—the provision of headquarters, stenographic service, expense funds—make concrete the policy of avoiding paternalism and fostering local initiative. The same policy lies back of the requirement that the community contain social agencies that can do the preliminary and follow-up work of the clinics. Actually, few Illinois towns have case work agencies that are equipped to do this work, and interested probation officers, school nurses, and others are accepted as substitutes. Insistence on the medical profession's interest and on local arrangements being made for physical examinations attests to both this policy of local self-reliance and another one that aims to avoid conflict over the question of state medicine. Various plans for physical examinations have been tried. Occasionally a clinic's psychiatrist has done this work. In some communities, local physicians have volunteered their services. Referral of patients to their family physicians is the custom in some communities, and in others the county physician has been used or the work has been financed by the local relief agencies. Much the same sort of difficulties are met as were reported for the Massachusetts habit clinics, but the Institute is fairly insistent that, by one means or another, the communities shall find a way to furnish this part of the clinical services.

The procuring of suitable local agents has sometimes been difficult. The usual plan has been to appoint as agent a staff member of the agency that offers to finance the clinic. The agent is responsible for handling applications, scheduling appointments, supervising the securing of case histories, preparing follow-up reports, and corresponding with the Institute in regard to policy, dates, and so on. To be satisfactory she must have capacity for leadership and good standing with the other agencies. She need not personally secure the case histories and later reports, unless other facilities for doing so are lacking, but, without creating ill feeling, she must be able

to stimulate other agencies to carry on this work. If she represents the agency that contributes the funds, it has been found that her position is apt to be stronger than if she is an independent appointee or a volunteer, but this plan also has drawbacks.

The funds to be guaranteed by local sources vary with the distance of the community from Chicago and, of course, with the number of sessions held. The Institute's plan is to conduct clinic sessions for periods of two or three days from one to four times a year. For each session the Institute social worker comes to the town a day before the psychiatrist and psychologist. Planning of financial arrangements is left entirely to the community, and sources of support vary from individual private contributors to agency or county funds.

Between 1923 and 1936 sixteen clinics were established and seven were discontinued. For the most part they were located in the northern and central parts of the state and in somewhat larger towns than those reached by the New York State Department of Mental Hygiene, the populations served varying from 30,000 to 70,000. This is attributable, no doubt, to the Institute's requirement of social resources (southern Illinois is largely rural and lacking in social agencies) as well as to the cost of transportation. Although the earlier plan called for making the clinic the center for the surrounding rural district, experience has shown that this is not practicable, for each community has more than enough cases of its own. The present arrangements limit the clinics' intake to residents of the cities in which they are held, and requests from other localities are handled independently by the Institute.

In accordance with their child guidance interest, the clinics strictly limit the quantity of their intake. The 1936 annual report reads, "The emphasis is on the careful study of a se-

lected group of representative cases rather than on a superficial study of a large number of cases."²⁸ The number of children examined per day varies with the types of problems they present, the clinic's accommodations, and other factors, but the minimum is seldom less than three cases, the maximum seven, and the average number four or five. With allowance for a daily staff conference, a three-day clinic can sometimes handle eighteen or nineteen new cases, and a two-day clinic twelve or thirteen, but the usual range is from twelve to fifteen and eight to ten, respectively. Except when mental defectives are being examined, the aim is to keep the intake low and leave ample time for discussion with parents, teachers, and social workers. Even so, the traveling clinics average more new cases per day than the main clinic in Chicago, where the daily rate is less than three per clinic unit. The explanation lies partly in the simpler procedure of the community clinics, for examinations in Chicago may include laboratory tests, recreational interviews, and other procedures not feasible in the smaller cities. Then, too, many of the patients have been examined medically by local physicians before coming to the clinic.

The clinics frankly request the referral of children of average or superior intelligence whose difficulties are suggestive of future delinquency or personality maladjustment, but they accept as patients a certain number of children suspected of being mentally defective, since such children present problems to the communities, and the state institutions for the feeble-minded have not been able to provide adequate field service. Cases of school retardation, classroom maladjustment, and specialized intellectual disabilities are included in the preferred group, because they call for advisory work with the schools and for the sort of treatment and supervision that

²⁸ Ibid.

the schools themselves can carry on with similar cases. Actually, the children referred tend to be of rather low intelligence, although not many are feebleminded.

The procedure of the clinics is fairly simple. It is expected that the local workers prepare the social case histories according to an outline form that is provided by the Institute and that the local agent of the clinic mail them to Chicago sufficiently in advance of the clinic's sessions so that they may be reviewed and summarized there and suggestions made by the clinic social worker before the day of the examination. The clinic social worker comes to the community a day ahead of the rest of the staff and spends part of that time in conferring with the local workers regarding the histories and other clinic arrangements. She makes no home visits, however, nor sees the families of prospective patients, except possibly when they bring their children to the clinic. Appointments are arranged by the local agent with, initially, some help from the clinic social worker. The usual procedure is to have the children examined by both psychologist and psychiatrist, while the parents, who are urged to come to the clinic with their children, are interviewed by the psychiatrist or the social worker or both and are usually given advice in regard to handling their children's problems. Return visits are suggested in some cases but, for the most part, treatment is left in the hands of the referring agencies.

Conferences between staff members and persons interested in the patients are frequent. Teachers often discuss their classroom problems with the psychologist. Nurses and social workers are seen individually and in groups for discussion of treatment methods. A certain number of "open staff meetings" are held at which selected cases are described and discussed before invited groups representing the schools, courts, physicians, and social agencies.

Letters reporting the clinic's findings and suggestions for

treatment are sent by the psychiatrist to the referring agencies or parents after the staff has returned to headquarters. These letters are based on the recommendations drawn up in the closed staff conferences that end each day's work, at which time the findings of the examiners are reviewed, new data are noted by the social worker, and suggestions for treatment are formulated. The psychiatrist reviews these in his reporting letter, making such modifications as he deems necessary in consideration of the person to whom the letter is to be sent. The majority of recommendations consist of practical advice with respect to physical care, recreation, placement, and school changes, and further vocational and psychological tests. A study of a group of cases referred to the Springfield clinic²⁴ in 1928-29 found that seventy per cent of the recommendations were of this nature. The rest called for interpretation of the child's behavior to the teachers and parents and for case work to effect changes in parental attitudes.

It is planned that every child examined be assigned either to the local agent of the clinic or to some other local person who will attempt to carry out the recommendations. Whenever feasible the social worker who secured the history continues to be responsible for the case, but actually teachers, nurses, probation officers, and social workers are variously responsible, according to the community's resources. As was reported for the traveling clinics of other states, the question how to carry on the follow-up work effectively is a serious one. The study mentioned above showed that forty per cent of the recommendations made to the Springfield clinic (considered one of the best at that time) were not carried out, the failure being largely due to pressure of work, inter-agency misunderstandings, and lack of facilities. Nevertheless, it was

²⁴ Jane L. Brown, "The Follow-up Procedure of an Intermittent Child Guidance Clinic," unpublished thesis, Smith College School for Social Work, 1931. Published in abstract form in *Smith College Studies in Social Work*, Vol. II (1932), p. 368.

found that a year after being examined at the clinic forty per cent of the children had improved greatly in social adjustment, a proportion which compares favorably with that found in urban child guidance clinics.²⁵

The state staffs enter into treatment only through their interviews at the clinics, but they do a considerable amount of work as consultants there. The relationship between a local worker and a clinic social worker has been described as that of student and supervisor. "The function of the visiting social service in any new district," states an early publication of the Institute,²⁶ "is largely educational. As soon as an organized group, preferably a general welfare agency, is able to take over the problems of investigation and treatment, the visiting social service has completed the greater part of its work. From then on the contacts are advisory only." In each of the community clinics this stage of advisory service has been deliberately hastened, since the aim of the program has been not only to develop community consciousness of incipient social problems but to cultivate in the local workers the understanding and resourcefulness necessary to deal with them. The adjustment of the individual child is not overlooked, but the individual case is regarded as serving its best purpose in being a means of teaching. It is recognized that even if the two or three hundred children examined each year were permanently readjusted, there would be no appreciable decline in the rate of delinquency. The traveling clinic service is offered, therefore, on the theory that the local agencies can be taught by the clinics how to carry on their own child guidance work.

²⁵ For such figures, see Helen Leland Witmer, "A Comparison of Treatment Results in Various Types of Child Guidance Clinics," *American Journal of Orthopsychiatry*, Vol. V (1935), p. 354.

²⁶ Cornelia D. Hopkins, *A Mental Health Program for Children in the Small Town*, Illinois Department of Public Welfare, Institute for Juvenile Research Publications, 1924, p. 4. This policy was in effect in 1932, when our investigator made a detailed study of the situation, and it is probably still (1939) adhered to.

Stated most generally, then, the Illinois program represents an attempt to develop through clinic demonstration local responsibility for the prevention of delinquency and other personality disorders. The state recognizes that all the needed services for such a program cannot be supplied by the local communities but its hope has been that gradually cities will recognize the need and supply adequate facilities for psychological and medical examination and for case work or other forms of treatment. In such a situation the state would be prepared to meet the costs of psychiatric examinations, this being deemed a proper division of state and local responsibilities. The ten years in which the bulk of the demonstration work has been done may not have been adequate ones in which to test such a theory of division of work, for the economic depression has been a great handicap to all such efforts; but there is little evidence so far that the plan can be realized in its entirety in any near future. A study of the local problems suggests some of the reasons why this is so.

One important explanation is found in the undeveloped, rural character of much of Illinois. Although the clinics are held in the larger, more socially enterprising towns, most of them are handicapped by a scarcity of resources that are taken for granted in the communities in which, for instance, the Massachusetts clinics are located. Trained case workers are rare, few courts have professionally trained probation officers, and schools seldom make provision for any sort of field workers. In the southern part of the state—which has barely been touched by the Institute's program—conditions are much worse than in the north, both in lack of resources and in frequency of social and economic problems. The Illinois Children's Home and Aid Society is the only organized social agency that has assumed responsibility for work in most of the southern counties. When the Institute's aim of arousing interest in and help for the emotional problems of children

is considered against the background of such conditions, one of the reasons why the program has encountered difficulties becomes clear.

By 1938 only two communities had developed the hoped-for facilities and point of view, and in both of these especially favorable conditions existed. The one is Winnetka, a wealthy suburban Chicago community, noted for its progressive school administration. The Institute supplied a psychiatrist for weekly sessions, and the schools employed their own psychologist and psychiatric social worker. Later, believing that the teachers had become adequately equipped to deal with the usual problems of child guidance, the school dispensed with its social worker and employed a psychiatrist for full-time work. The other community in which adequate resources have developed is LaSalle, where through private funds the Bureau of Educational Counsel has been set up in the township high school and junior college. This project is an outgrowth of the original mental health survey in 1923, and a trained case worker was placed in the high school at that time. To this project the Institute sends a psychiatrist once a month.

The nearest approach to self-sufficiency in a more typical situation are the developments in Springfield, the state's second largest city. There a clinic was established in 1925 under the auspices of the Children's Service League. Good relationships among the city's social agencies existed, and several of them were staffed with trained workers. Recently they have assumed complete responsibility for the social work of the clinic, and the Institute sends a psychiatrist and psychologist to the three sessions of three days each that are held each year. A plan of adding a psychologist to the staff of the Association of Welfare Agencies has also been considered. In two other centers (Champaign-Urbana and Decatur) psychological testing is supplied by the schools. This slow development of resources to take over the clinics' work is not greatly different

from the situation in Chicago itself, however. The main office of the Institute has also considered its work a demonstration and hoped that the local agencies would learn from it how to carry on much of the treatment of their own cases. After years of consultation and cooperative work, however, the Institute still finds it necessary to supply the case work services for at least a fourth of the patients under treatment.

In addition to the inability of the communities to assume a larger share of the clinic work, other difficulties have been found that are similar in kind but perhaps more extreme than those reported in other states. The situation appears to be a rather paradoxical one. For it seems that the better equipped the clinic and the more attention that is paid to soliciting cases of emotional maladjustment, the more acute the difficulties that arise in carrying out the local programs. In Illinois, as in New York, the chief complaints of our informants centered about the inadequacy of the case histories and, particularly, about the meagerness of the treatment efforts, especially as they related to recommendations involving more than school or placement adjustment. Operating in small towns, the New York clinics worked largely through the schools and the county children's agents and so received a large proportion of cases that could be treated by school or foster home changes. The Illinois clinics, on the other hand, were located in larger cities, consequently worked with a wider variety of social agencies, and recommended treatment that more frequently involved work with parents. The staff social workers gave more time to conferences with local workers and greater emphasis was put upon child guidance problems. The results in terms of community education may have been more favorable (we had no way of judging this), but it appeared certain that local jealousies and conflicts were more frequently aroused.

At the time of our 1932 survey, clinics were being held in

eight communities, two of the clinics being joint efforts of two or three towns. In four of these communities, the clinics appeared to be fairly successful, in so far as interest and cooperation were concerned. Two of them were located in large cities with well-equipped social agencies and other resources; the other two were in smaller towns that had no trained case workers, and the referrals came almost wholly from the schools and nursing associations. Even in these four communities, however, there was much feeling about the inadequacy of the follow-up efforts. In the other centers there were additional problems: lack of finances, inter-agency conflict accentuated by one agency being chosen the clinic's representative, unsatisfactory referrals, and rather frequent complaints that the clinics' recommendations were not practical and their sessions too infrequent. In all communities there were many people who were enthusiastic about the work but they tended to be either trained case workers who could make use of the consultation services or other professional persons who liked the concrete recommendations. To the untrained social workers the clinics were apt to be a threat, as was the suggestion, frequently made, that psychiatric social workers be employed locally to carry out the treatment plans.

It appeared in general, then, that to carry on child guidance through traveling clinics requires cooperative social agencies, schools, and courts that have on their staffs persons who are professionally equipped to deal with emotionally maladjusted children. The Institute for Juvenile Research has recognized this in the criteria it has set up for community participation in its program, but its experience leads to doubt as to whether, in actuality, such conditions do exist. Lacking those conditions, the program is likely to falter because it asks of communities services that they are not equipped and probably cannot, through the medium of occasional conferences, be equipped to give. Anticipating our findings in a later

chapter, we may even raise the question as to whether it lies within the proper function of most local agencies to undertake such therapeutic work.

CALIFORNIA BUREAU OF JUVENILE RESEARCH
COMMUNITY CLINICS

The traveling clinic program of the California Bureau of Juvenile Research will be described only briefly, both because it has had such a checkered career that generalizations may be unjustified and because it has never been staffed adequately enough to provide much service. As with the Pennsylvania program our findings refer wholly to the situation in 1932. They seem to us to be of interest because they suggest what some of the effects may be when clinics achieve the objective of securing child guidance types of patients, give considerable time to the study of each case, and yet are able to visit communities only very infrequently. The situation in California thus has some points in common with that of Illinois, but differs both in staff equipment for the work and in methods of promoting clinics and giving service.

The program of the Bureau of Juvenile Research is an outgrowth of the interests of the Whittier State School, a reform school for delinquent boys. In 1912 a return to the original plan was arranged with Stanford University for a psychological survey of the children, which resulted in 1917 in the establishment of the Department of Research at the School. By state law this department was authorized to make clinic diagnoses of the inmates of this and other institutions and to "carry on research into the causes and consequences of delinquency and mental deficiency and . . . social, educational and psychological problems relating thereto."²⁷ The School's clinical psychologist was legally designated the head

²⁷ California—*Statutes and Amendments to the Codes*, 1917, Extra Session, 1916, Chapter 223, Sec. 1.

of the research department. In 1921 the name of the department was changed to the California Bureau of Juvenile Research, and the direction and control of all juvenile research and psychological work in state schools, homes for the feeble-minded, and other state institutions were put into its hands. Two years later the Bureau was discontinued for lack of funds, but research activities were continued at the Whittier School and a program of social work with the families of delinquent boys instituted. During this period clinic work with the boys was expanded and individualized plans for their education and rehabilitation were formulated.

In 1929, following the report of the State Commission for the Study of Problem Children, the Bureau of Juvenile Research was restored, with the tacit understanding that it was to function as a statewide organization. The Commission²⁸ had found through public hearings that "there was universal agreement regarding the desirability of early clinical analysis of maladjusted children," and it recommended strongly "that everything possible be done to encourage communities to develop adequate child guidance clinics of their own or in cooperation with nearby communities." Then, since the possibility of rural centers undertaking such a program was remote, it urged that "there should be further extension of the work of traveling clinics operating from state institutions," citing with approval the work of this nature in Illinois. The new director of the Bureau, a psychologist who had been the research consultant for the Commission, put into operation a program of "visiting clinics" that was frankly modeled after that of Illinois. Since that time, due to political and economic conditions, the clinic program has had a tempestuous existence and at present (1939) is decidedly curtailed.

Presumably the visiting clinics' objectives were much like

²⁸ *Report of the California Commission for the Study of Problem Children*, January 1929, Sacramento, California State Printing Office, p. 18-19.

those of the Illinois program. It was emphasized that they were educational efforts, designed to stimulate in the larger cities the development of local resources to deal with the problems of emotional maladjustment, while to the smaller communities they offered periodical services. Even more explicitly than in Illinois, cases of the child guidance type were solicited, and the demonstration nature of the clinics was stressed. An early bulletin of the Bureau²⁹ states:

A visiting clinic is designed primarily to study children who are a source of concern to parents, teachers, or others in the community and whose condition seems to indicate that physical or bodily causes are not explanatory of their difficulties. . . . In cases in which the condition is obviously one of feeble-mindedness, the child should not be referred to a clinic of this type, except possibly for purposes of diagnosis or confirmation of diagnosis.

Since the primary object of the clinic is demonstration rather than complete clinical service, a diversity of cases is more desirable than uniformity. . . . Cases should be selected so that all persons in the community who are vitally concerned with the welfare of children will be interested in them.

Other similarities to the Illinois plan are to be seen in the following policies and procedures. Clinics were held in communities "only upon the united invitation of all the important local groups interested in child welfare and with the understanding that the community will assume responsibility for part of the maintenance of the staff while it is in the community."³⁰ Originally the financial arrangements were like those of Illinois (the communities paid all traveling and

²⁹ Norman Fenton, *The Organization and Purposes of the Visiting Child Guidance Clinic of the California Bureau of Juvenile Research*, Sacramento, California State Printing Office, Bulletin No. 4 (April 1931), p. 8.

³⁰ Dorothy Brinker and Norman Fenton, *The Visiting Child Guidance Clinic of the California Bureau of Juvenile Research; Manual for Community Workers*, Sacramento, California State Printing Office, Bulletin No. 5 (August 1931), p. 3.

maintenance expenses), but later a flat charge of fifteen dollars a day was agreed upon, since the other plan was found too burdensome. The group issuing the invitation formed a "citizens' committee," but most of the practical details were put in the hands of a "working committee," whose chairman carried on the function of local representative of the clinic. These chairmen, the local agents of the clinics, were preferably trained case workers or visiting teachers but, since many communities had no such workers, nurses, school counselors, and other child welfare workers were often used instead. Social case histories were secured by them or under their supervision. It was requested that résumés of the histories and reports of the medical examinations—which were made by local physicians—be sent to the Bureau's headquarters in advance of the sessions. As in most other states, the work of carrying out the clinics' recommendations for treatment was left in local hands.

According to the plans, the clinical unit went to a town for three or four-day visits, the social worker, as in Illinois, preceding the rest of the staff by a day or two. On those days she conferred with the local agents in regard to the social case histories and the details of the schedule. Then, during the sessions, she acted as clinic manager and interviewed the parents regarding further details of the children's life and environment. In the meantime the children were examined by the psychologist and the psychiatrist, not more than two cases per half-day being scheduled. At the end of the day staff conferences were held, to which the local workers interested in the cases came and at which the staff's findings were reviewed. Possible treatment plans were considered at that time, but definite recommendations were made later by means of a reporting letter. In addition to these conferences, open meetings for demonstration of the clinic's working methods were held at least once during the staff's visit to a locality.

Between 1929 and 1932, when our study was made, fifty-three clinics were held in twenty-six communities, and 118 children were examined. The towns varied widely in size, from Goleta with a population of 600 to San Diego and Long Beach with over 140,000. The great majority of towns had less than 20,000 inhabitants, and were located in fifteen counties in the southern part of the state. The financial sponsors of the clinics were predominantly schools, parent-teacher associations, service clubs, and, occasionally, local mental hygiene societies, while the clinics' agents were largely school nurses, attendance officers, and county health officers. In other words, due partly to the lack of social agencies, the clinics worked chiefly in and through the schools. About three-fourths of the children examined were referred by school authorities, and there were no referrals from social agencies.

With a few exceptions the clinics met only once a year in any given town, and there was considerable turnover in communities. To four of the seven communities visited in 1929-30 the clinics did not return during the three-year period, and the same situation obtained in four of the eleven communities visited in 1930-31. By 1931-32 clinics were being held in thirteen communities, seven of them being visited once a year and three twice a year for four-day periods, while three communities near to headquarters had bi-monthly visits of one day each.

The staff at that time was divided into two units, consisting of psychiatrist, psychologist, and psychiatric social worker, the latter two being specially trained for clinic work with children. The psychiatrists were secured from nearby mental hospitals, while the other workers were engaged full time in the service of the clinics.

Children referred to the clinics were in the main the types the clinics desired to study. Only about twelve per cent of the 1929-32 cases had an I.Q. under 80. The great majority

of children were brought to the clinics because of either school failure or personality difficulties and only two out of the 118 were referred because of mental defect.

Our survey of the communities in which the clinics were held revealed much the same opinions as were manifested in other states. By and large, the schools were enthusiastic about the work and said they had learned much about child guidance from the clinics, though, from a practical point of view, they found the visits too infrequent and the number of children studied too small. One school had met these difficulties by forming a "school clinic conference," in which the teachers, school physician, nurse, and psychologist secured social histories of problem children, made psychological and physical examinations, and worked out treatment plans, whose execution was entrusted to the school nurse. It seemed to our informants that in this case the educational activities of the clinics had overcarried, and it was cited as an example of what might happen generally if a clinic's educational program makes mental hygiene treatment appear to be very simple.

Outside the schools more criticism of the program was met. In some communities it was felt that the open staff meetings and other publicity attendant upon the clinics militated against the success of the work since, even though secrecy in regard to individual cases was maintained, they aroused gossip and antagonisms. Then, too, as in other states, there were many complaints about the lack of facilities for carrying out the treatment recommendations, particularly since the interest of the probation officers, child welfare workers, and other social agencies had usually not been secured. A third criticism (which was articulated in California but which must represent a difficulty to be met everywhere) was that the clinical program necessarily implied an adverse comment on the community's previous methods of handling a case and that

this natural sensitiveness was intensified by the clinics' rather arbitrary regulations in regard to reports, headquarters, conferences, and the like, following upon the requirement that the community take the initiative in requesting the clinics' help.

In general, then, it seemed that this program had achieved some of its objectives but had met some, perhaps unforeseen, obstacles. It had secured the referral of the types of cases it chose to work with, and the small intake (cut from four to three to two cases per day) permitted the intensive study and discussion that was deemed necessary for the education of the public. At the time of our study its case workers and psychologists had some training in "guidance work" but the psychiatrists had had little experience with children. Reviewing the work of the clinics, the 1930 Mental Hygiene Survey of California reports:⁸¹

The records inspected were found to be of good quality, particularly so when the fact is considered that many were prepared by persons having had relatively little training in this field. . . . Considerable discrimination has been shown in the selection of material to be included. Particularly good psychological examinations have been made, but the psychiatric examinations by the state hospital psychiatrists have not given an adequate picture of the child.

Since the social histories were procured and the treatment carried by local workers and few of the children had low mentality, this inadequacy in psychiatric services was particularly handicapping. It had seemingly led some schools to the conviction that they could carry on clinic work without additional resources, and it probably widened the breach between psychology and psychiatry which was already present in California.

⁸¹ Frederick H. Allen, *Mental Hygiene Survey of the State of California*, op. cit. (Ch. V, n. 13), p. 26.

SOME CONCLUSIONS IN REGARD TO CENTRALLY
ADMINISTERED PROGRAMS

In the beginning of this chapter the primary problem of the centrally administered mental hygiene programs was stated as that of working out some method by which psychiatric services could be made available to children outside large cities. The descriptions of the individual programs have shown the two main policies that have been pursued: one looking to the eventual assumption of responsibility by the state hospitals, the other attempting to stimulate the development of local resources. New York, Massachusetts, and Pennsylvania follow, with more or less vigor, the first plan; Illinois and California, the second; but all of them, in one way or another, recognize that the central departments will probably always have to provide some part of the clinic services. Sometimes this is seen as taking the form of complete service to certain areas. The Massachusetts Division of Mental Hygiene, for instance, calls certain of its clinics "permanent," and the California plan recognized that some towns would be too small ever to provide even a part of the personnel. More frequently the policies anticipate that the communities or the hospitals will eventually provide some of the needed staff, while the state may continue to finance the rest.

These states have now carried on their programs for from ten to fifteen years, but during that time most of them have been handicapped by the severe economic depression, which has so affected both state and local funds as to make conclusions regarding the feasibility of their policies dubious. On the other hand, most of them were well under way during a period of unusual prosperity, so that results cannot be attributed to financial stringency alone. It has been shown individually above that progress toward the goal of either state hospital or local maintenance of clinic units has been slow. In the three states that would make the mental hospital

the center of clinic activities, some hospitals were already conducting clinics when the state departments began their work. In New York several other hospitals have started outpatient work with children since they have come under the supervision of the Department of Mental Hygiene, and the clinics conducted by the Division of Prevention's field staff have been discontinued in the eastern area. Pennsylvania's program always did make use of the psychiatrists from some mental hospitals but relationships with other mental hospitals were not very cordial. In Massachusetts, where the habit clinics were originally set up as frank demonstrations to the state hospitals, only two hospitals have absorbed them into their clinic programs, while in one city local agencies and the state hospital have united in providing services for children. The director of the Division of Mental Hygiene now seems to be of the opinion that it is useless to urge the state hospitals to provide clinics for children unless they are given enough money to employ psychiatrists and social workers adequately trained for this work.⁸²

From the point of view of numbers, then, it would appear that the policy of developing clinic services through the state hospitals has not been very successful. Even if it were achieved, the findings of the preceding chapters as to the feasibility of serving children through state hospitals as they are now equipped would still stand. The more hopeful approach (from the patients' point of view at least) would seem to be that of the other states—those that look to local resources for the major part of the clinic services. The descriptions of this work in Illinois and California have shown, however, that it too proceeds under difficulties. There the whole traveling clinic plan was set up for demonstration and education. The communities' resources were carefully looked into before clinic units were assigned to them; the towns had to give evi-

⁸² See p. 211-212.

dence of their interest by helping to finance the clinics and by providing them with various sorts of service. The states' policy was to discontinue the clinics, at least those outside of rural areas, if within a reasonable time local resources for psychological examination and case work treatment did not develop. In addition, emphasis was put upon securing child guidance referrals, and a rather large amount of time was given to conferences and discussions with local workers about the needs of the patients. Our conclusions as to the effects of these policies in Illinois have been set forth above. It seemed that there were handicaps on both sides. The clinics, although staffed with well-trained case workers, suffered from a rather rapid turnover in psychiatrists and from lack of intimate knowledge of local conditions. Interested in the intricacies of modern case work and psychiatry, the clinics may have been something of a threat to local workers. On the other hand, even though most of the clinics were placed in rather large cities in the northern part of the state, local resources were frequently not adequate for the type of work contemplated by them. Progress toward the goal of local self-sufficiency was made in some cities and interest in mental hygiene was undoubtedly aroused, but in terms of developing the means of affording treatment to problem children the net results of about fifteen years' work did not appear to be large. In California, where much the same policies were pursued, more difficulties appeared. There the local resources were even less adequate and the clinic staffs less well equipped for their work. Politics entered to complicate an already difficult situation, and at the time of our study the whole issue was so beclouded as to make evaluation almost impossible.

Such an analysis of the Illinois plan suggests another way of viewing the objectives of a state-directed program. It was pointed out in the beginning of this chapter that the basic question is not so much who shall provide the money as how

local interest and cooperation can be secured, so that the children who need help will be referred to the clinics and receive the sort of treatment that is indicated. With respect to referrals, New York apparently pursued a passive policy of granting to small communities their requests for clinics on their own terms, accepting whatever types of patients they wished to send to them, and adapting their recommendations to the communities' understanding and resources. Little direct effort was expended on mental hygiene education or the stimulation of additional local resources, for it was rather expected that eventually the state hospitals would take over the work. In spite of this apparently easy-going policy, or perhaps because of it, there was a gradual change in the patients referred to the clinics, with fewer feeble-minded and more emotionally mal-adjusted children appearing among them. With this change, the question of carrying out the treatment recommendations gave evidence of becoming more prominent, but by 1932 little seemed to have happened except that the overworked school nurses and county children's agents were aware of the need. Pennsylvania's program put even less responsibility upon the local areas. Being primarily a service of psychological testing and designed to supplement the work of the state hospitals, it made so few demands—going even so far as to do away with the local agents—and gave so little general education that perhaps by these very policies it may have stimulated a desire for something different. That is doubtless not the whole explanation, but it is a fact that a greater interest in setting up local child guidance clinics was evidenced in Pennsylvania than in any of the other states.

As to the follow-up work, it is widely recognized that diagnosis without the possibility of treatment is futile, and all the state programs attempt to secure some means by which the recommendations of the clinics will be put into effect. These methods, described above for the individual programs,

range from making the field representatives responsible for the supervision of all mental defectives, holding interpretative case conferences with local workers, and offering consultation on individual cases to the Massachusetts plan of providing treatment by the clinic staff itself. There is apparently much variation in the quality and quantity of the follow-up work, but most observers and participants agreed that no really effective scheme has been worked out. Our investigators found that even when the social workers preceded the rest of the staff in their visits to the communities and remained after them for a day or so, the same complaints appeared that not enough time was allotted for discussion and supervision. Child guidance is apparently an insatiable taskmaster. Dr. Thom³⁸ of the Massachusetts Division of Mental Hygiene observes: "As we have advanced in our knowledge with reference to behavior difficulties and have more to give in the way of help to parents and children each case becomes more time-consuming." His suggested way out of the dilemma is to turn over the work with the less serious cases to parents, teachers, and social workers; but it is just this matter of finding time to train or supervise local workers (and of the local representatives finding time to carry on the clinics' work even if they are supervised) that has caused the difficulties in the other states' programs.

Even the Massachusetts plan of setting up clinics that do most of the work themselves is not without its handicaps. At first thought such a method appears to be the simplest way of dealing with the knot that binds children's needs and communities' inadequacies in resources. Even aside from the financial outlay which such a program would impose upon a large state, however, difficulties are encountered in that plan, and they would probably become greater if the clinics oper-

³⁸ Douglas A. Thom, *Annual Report of the Massachusetts Commissioner of Mental Diseases for the Year Ending November 30, 1935*, p. 48.

ated over a wider area than that of Boston and its suburbs. The central problem is that of securing interest and understanding of the clinics' work on the part of the schools, social agencies, courts, and other professional persons through whom children are referred to the clinics and by whom assistance must be given. This problem exists in all child guidance clinics, of course, and would not seem to be particularly accentuated because the habit clinics are financed by the state. The difficulty, in so far as it exists (and some of the Massachusetts clinics are free of it, since they operate in the highly professionalized urban area in which their headquarters are located), seems traceable to the fact that the state clinics cannot be integral parts of the community structure. They have no representative on hand to respond to those spontaneous requests for help which agencies and individuals make; they cannot take much part in the local activities through which so much of mental hygiene interpretation must proceed. Like the clinics of the other states, they also are too busy on the days of their periodic visits (even though they are frequent ones, for the most part) to carry on the slow work of education and interpretation case by case which is the urban clinics' method of peaceful penetration.

Such an analysis of the work of the state-directed programs may appear to be unduly pessimistic. It must not be overlooked that state clinics have provided many rural and small-city children with an understanding examination of their difficulties that might have been denied them otherwise. And, in many localities, the clinics have undoubtedly fostered in teachers, nurses, and social workers an interest in mental hygiene. Nevertheless, it cannot be maintained that the objective of developing local or state hospital services that will adequately meet the needs of the children outside of urban areas has been significantly forwarded.

It appeared that, left to follow their own wishes, most

rural communities would use the clinics chiefly for diagnosis and advice about feebleminded children and others who cause them concern in school. If the clinics endeavored to stimulate the referral of other types of cases, the character of their intake did change but treatment facilities altered little. Even when the clinics themselves assumed most of the follow-up work, the handicaps in the local situations remained. As demonstrations and education, then, there was not much evidence that the programs were a great success. What seemed to be needed was some method of working from the local community upward to the state's facilities rather than a plan that moved in the opposite direction.⁸⁴ Some means of securing permanent, local representation of the program (whether state financed or not, it would not seem to matter) might accomplish that stimulation of local interest and initiative, the lack of which is a handicap to so much of the present work of the clinics.

⁸⁴ For a brief description of such a project, now being financed by federal funds in the California Department of Social Welfare, see p. 411-413.

III

Principles for Future Programs

CHAPTER NINE

Organization on the Basis of Function

OUT of the mass of divergent policies and practices of the state-financed psychiatric clinics for children it is difficult to draw accurate generalizations. The few that emerge, however, make it clear that the clinics rarely conceive their objectives in terms similar to those of modern child guidance, that most of them are not equipped for such work nor supported in it by the communities in which they operate. There are thus both inner and outer obstacles to effective psychiatric service for children under state auspices. It would seem, however, that an analysis of the nature of these obstacles and the character of the disputed points in clinic policy should lead to a clarification of the problem and perhaps point to a way out of the difficulties. Such is the purpose of this chapter.

SOME DIFFICULTIES THAT CLINICS MEET

The traveling clinics of most state hospitals and central governmental departments spend the greater part of their time examining children of low intelligence or those whose difficulties are attributed to organic causes. Concerning such children they so frequently offer recommendations for custodial care that one comes to doubt whether the original aim of reducing institutional admissions is being significantly forwarded. This work of diagnosis is, however, generally received with appreciation by certain sections of the community, usually the schools and the courts. When it is recalled that in most small towns there is likely to be no other official source of expert opinion regarding the intellectual capacities of children and that neurological diseases are relatively rare and so

outside the scope of many physicians, it is clear that there is need for the services of these clinics. Nevertheless there would appear to be either some serious faults in the system or some deep resistance on the part of the general public, for our survey revealed almost no clinics whose services were frequently sought by either parents or physicians, the two groups that might be thought to need them most.

If, on the other hand, the traveling clinics try to extend their work to include typical child guidance patients they also encounter obstacles, some of which are peculiar to rural work. To suggest that misbehaving children be sent to a doctor or to interfere with the processes by which the quiet, shy ones keep out of mischief has frequently been found to run counter to small-town theory and tradition. Then, too, parents of either of these kinds of children are reluctant to risk the stigma of the state hospital, and overburdened teachers are often doubtful that a single examination of a child of adequate intelligence by outsiders can tell them much they do not already know or can suggest measures they have not already tried. If, however, through education or through the work of some especially capable person in the community the clinics do achieve their objective and their patients become largely the types they desire, other difficulties appear. For such cases require treatment rather than diagnosis, and the facilities for treatment are usually lacking, both in the clinics and in the communities. Most of the clinics' psychiatrists are not trained for child guidance work. The few social workers who do have adequate training are allotted too little time in any one community for case work. If the towns contain inadequate social services, the work of the clinics is handicapped; if they do have well-trained case workers on the staffs of the social agencies, such workers are inclined to be dissatisfied with the methods of the clinics.

Nor are all difficulties overcome when the clinics operate in

large cities with many resources. In some such centers the clinics are frequently staffed primarily by psychiatrists and have an inadequate number of social workers for a child guidance type of treatment. There the medical tradition of diagnosis and prescription predominates and, in addition, the clinics are often used chiefly for giving groups of young doctors a little experience in work with children.

There thus appear to be various reasons why the attempts to extend psychiatric facilities to meet the needs of children who live outside of large cities encounter difficulties. Some lie within psychiatry itself. Many of the traveling clinic programs are based on the psychiatric theory that is concerned chiefly with mental disease and builds its practices in accordance with medical analogies. This point of view frequently persists in subtle ways even when lip service is paid to more modern teachings, such as those of Adolf Meyer. Other reasons for the clinics' difficulties are to be found in programs that call for serving large areas with small and inadequately trained staffs. The personnel of a clinic, it has been shown, is commonly drawn from the regular hospital staff, the work often being looked upon as a kind of extracurricular activity that will develop new enthusiasm among staff members who may otherwise "go stale." A hospital is rarely able to engage additional persons to carry on a clinic program, and even when one or two are assigned full time to the work, so many towns are covered that adequate service to any of them is impossible. For the most part, only diagnostic service is offered, it being the aim of some programs and the hope of others to stimulate the towns to provide the personnel through whose help the clinics' recommendations can be carried out.

The third source of difficulty is found, then, in the meager resources for assistance to problem children. In large sections of the country there are no trained case workers, institutions of all types are inadequate, even medical services are insuffi-

cient for the needs. The bulk of the clinic work is therefore left in the hands of school nurses and child welfare agents who have rarely had training in mental hygiene and who already have more work of their own than they can properly attend to. Finally, psychiatric programs for children encounter difficulties in the traditional attitudes of both lay and professional public, which perhaps overvalues the rational, intellectual factors in human behavior. Intertwined with these attitudes are the fear and social stigma of mental disease which in many communities tend to keep all but the most desperate parents from seeking the help of clinics attached to mental hospitals or state departments of mental disease.

In spite of these handicaps it was clear to our investigators that the clinics are not without value and that some are highly prized. The wide agreement among commentators that clinics are needed, the appreciation of certain aspects of the clinics' work, and even the criticisms seemed to justify a further analysis of the difficulties which clinics meet and an attempt to derive from the present clinics' experiences some tentative suggestions for future work.

DISPUTED QUESTIONS OF ADMINISTRATION AND POLICY

The material that was collected in our study indicated that in all types of clinics in all types of settings there were certain common questions that puzzled the administrators and certain comments that were made by all the organizations and individuals that used the clinics. Not that there was unanimity of opinion. The diversity to be expected appeared throughout the country but it took much the same form whether the clinics were in large cities or small, whether they gave diagnostic or treatment service, whether they were manned by hospital staff or maintained an independent existence. On every question there were critics and defenders, and much of the time one felt that personalities played a larger part than theory or

policy in determining the response of both staff members and outside individuals. Nevertheless there were enough common elements in both the praise and the criticism to suggest that there were lines of cleavage that could be traced to more fundamental divergences. Perhaps a listing of some of the main points at issue is the best way of making this more clear.

Among the questions frequently discussed was what kind of staff the clinics should have. The question took two forms. It asked what professions should be represented on the staff and in what proportions; and what sort of preparation for clinic work should be required of these staff members. The staffs contain, in various combinations, psychiatrists, psychologists, and social workers, with, occasionally, additional physicians who make physical examinations and recommendations. In many clinics the staff consists of only a psychiatrist, who obtains as far as possible the necessary information about the patients from the persons who refer them to the clinic. In other clinics the psychiatrist is assisted by a psychologist, in others by a social worker; in some, both additional professions, in varying proportions, are represented on the staff.

The preparation of these individuals for their duties varies widely. Among the chief points at issue is that of whether it is best to use "ward psychiatrists" for the clinics or whether the psychiatrists who are to deal with children and with problems touching upon community relationships need special training for that work. The argument in favor of the ward psychiatrists rests upon the conviction that hospitals should be kept more closely in touch with the outside world, should be agencies of the community rather than citadels apart. It is believed that service in outpatient and traveling clinics is the best method of keeping the institutional psychiatrists in touch with community problems and community resources, and that through the participation of these psychiatrists the community's fear of mental hospitals will be broken down. The

argument is also made that psychiatrists can keep their touch with the problems of mental disease only through continual contact with hospital patients and that a separation of function disposes them to foreign points of view. On the other hand, there seems to be little doubt that the psychiatric study, not to say treatment, of children requires an understanding of feelings, motives, and human relationships in general that is probably not to be acquired through the study of the difficulties of psychotic patients alone. Then, too, quite aside from their validity, diagnoses of the mental condition of children are frequently of little value to the lay public to whom they are given. The recommendations that accompany such diagnoses are apt to meet obstacles in the reluctance of the responsible individuals—parents, teachers, judges, social workers—to act upon them, either through lack of conviction that they are for the best or through other indisposition to bring about the necessary changes. In other words, it is held by many that the study and treatment of mental hygiene problems in children require a knowledge of human relationships which goes beyond that included in institutional psychiatry and an understanding of the community and its resources and attitudes that is acquired only through long-continued contact and study. Those who hold to this point of view doubt that the same psychiatrists can adequately serve both inpatients and the children who are in difficulty with the world outside.

An even greater difference of opinion about the training of the social worker was found. The requirements for the position vary with the clinics. Many clinics have no social workers, others use workers from the hospital staff, a few have full-time workers of their own. Often social workers have been recruited from among the institution's nursing force; some have as the chief preparation for their duties a period of service in secretarial work—or even at the tele-

phone switchboard. At the other extreme, there are clinics that require graduate training in psychiatric social work and several years of experience in a psychiatric clinic.

No less varied is the type of work that is assigned to the social workers. In some clinics the social workers give the psychometric tests; in many their chief duty is to compile the material submitted by the persons referring the patients to the clinics and to supplement it by investigations in home and school if necessary. Sometimes they do what is known as "follow-up work" in cases in which no other professional individual can be held responsible for seeing that recommendations are carried out. The conception of follow-up also differs, and with it the social worker's function. It is probably correct to say that follow-up usually implies an attempt to put recommendations into action, and the psychiatric social worker is believed to be especially adept at this, for the psychiatric approach is often defined as "getting other people to do what you think they ought to do without arousing their antagonism." When social treatment thus conceived goes beyond a check-up of the activities of the responsible individual, it consists of attempting to effect environmental changes, of interpreting to the interested persons the needs of the patient, and of acquiring additional information that will help the psychiatrist in his therapy. Follow-up may be considerably different, however, when the "psychiatric approach" of the social worker is an attempt to understand the feelings of the patient or his family and to help them to clarify for themselves the courses of action they wish to pursue. Such a conception turns the social worker from being the "handmaiden" of the psychiatrist into his professional associate, and treatment becomes a matter of the cooperative effort of specialists, each with a well-defined function to perform. These diverse points of view seldom came to the surface in the discussions of clinic problems that were reported in our investigation, but it

seemed to the writer that they lay back of many of the comments regarding the role of the social worker in the clinics and that they explained much of the dissatisfaction that was sometimes reported to exist between trained case workers and psychiatrists.

Another point on which there was diversity in policy and opinion had to do with the types of children that were referred to and accepted by the clinics for study. The majority of clinics had as their aim reducing the number of admissions to mental hospitals and other state institutions. Their slogan might have been "an ounce of prevention," and the prevention aimed at was chiefly that of mental disease and crime. The services of such clinics, for the most part, were first offered to adults; and in that age group the criteria of mental disorder more or less likely to be indicative of potential psychosis or, at least, clearly within the realm of psychiatry had wide acceptance in the medical profession. Difficulty, from the clinics' point of view, arose when the services were extended to children. The argument in favor of that extension had wide acceptance, since it was generally agreed that many adults came to the clinics too late for much help. But when the clinics' services were offered to children (and the communities' understanding and sympathy with the clinics' aims were gained) the flood gates were opened, and the clinics found themselves overwhelmed with requests for assistance. At first they were sent the grossly feebleminded, those suffering from various neurological conditions, and the delinquents with whom nobody had been able to deal. Later came the aggressive, troublesome mischief-makers of the classroom; and then—frequently under the influence of the clinics' own educational program—the shy, withdrawn children, the very young children with habit disorders, and the children with specific psychological disabilities.

About this time many of the administrative authorities be-

gan to question whether these children were potential psychotics after all. Much of the work the clinics were doing seemed to these authorities (and sometimes to the clinic psychiatrists as well) to be outside the realm of psychiatry, and there did not seem to be that marked influence on hospital admissions that had been promised. On the other hand, many of the clinics, having found their most interesting and successful work among the children whose difficulties were of not too long standing or not too complicated by intellectual or environmental handicaps, were inclined to seek patients of that type and to say that the feeble-minded, the epileptic, the postencephalitic, and the like should be cared for by other organizations. At the same time the communities, if awakened to the mental hygiene needs of their children, tended to become impatient of the long waiting lists and to oppose the clinics' preferential treatment of any particular types of cases. This does not mean that most communities were dissatisfied with the work of the clinics; on the contrary, our investigators heard much praise of them. But as interest grew, so did the demand for services, and the types of children seen as needing help became more diverse. And the more successful the clinics became in securing as patients the children whose difficulties they could remedy, the less likely it seemed that they were treating potential psychotics.

Closely allied with these perplexing problems were those centering around the kinds of service the clinics should offer. For the most part the clinics gave what was called diagnostic service; that is, they examined the children referred to them by nurses, teachers, social agencies, physicians, and the like, and in the light of their findings they made recommendations for the treatment of the children to the persons who referred them. Occasionally a child would be seen a second or third time at the clinic, but usually this was because the psychiatrist needed more information about him rather than because he

was receiving treatment. This type of service met with obstacles. In many communities the persons who brought the children to the clinics did not have sufficient psychiatric understanding to make use of the recommendations, nor were the other resources of the community adequate for this purpose. Sometimes recommendations were misunderstood; more often they could not be carried out under the existing circumstances.

Difficulties of this type increased as the character of the referrals changed. When the patients were chiefly those with gross physical pathology or mental defect and the recommendations chiefly for physical care, change of school, institutionalization, or when the request for examination was made by a local physician who wanted a check-up on his neurological findings, the situation was not so difficult. When, however, the patients were sent to the clinics because of more strictly mental hygiene problems, other factors became more important. In the first place, the recommendations could no longer take such tangible form. "Change the parents' attitudes" became, for instance, a frequent suggestion, but that implied not only the presence in the community of some agency with skill in that area but also an interest and desire on the part of the parents for treatment. Faced with that situation some clinics used their social workers as interpreters and tutors, as it were, to the staffs of the local social agencies; others invited representatives of the referral agencies to staff conferences, at which the patients and the recommendations were discussed. Attempt was made in some clinics to interview the parents directly; in some, no cases were accepted unless the parents expressed at least a willingness to have the child examined.

In communities in which the knowledge of mental hygiene was not widespread among social workers and the rest of the professional public this plan seemed to work with consider-

able success, so far, at least, as the agencies were concerned. They reported great interest in the work of the clinics and satisfaction with the help they received. In communities more sophisticated along psychiatric lines, however, the attitudes of the referral sources tended to be not so favorable. This appeared to be due not so much to the character of the recommendations made by the clinics or their appropriateness to the problem at hand but rather to the fact that the social workers had usually arrived at much the same conclusions in their own investigations and what they wanted from the clinics was psychiatric treatment for their patients rather than advice. In other words, in these communities some social workers had sufficient knowledge of mental hygiene so that without help they could arrive at much the same conclusions as those offered by the clinic. Their need was for service beyond that point, and they looked to the clinics for treatment of their patients rather than for diagnosis and recommendations.

To this criticism most clinicians would reply that they had neither the time nor properly equipped staff. Then the discussion would turn again to the kind of cases that were referred to the clinics—some clinics deploring that the communities recognized only their most outstanding problems and ignored the less annoying children, others questioning whether they had already gone too far afield and into an area in which they were not prepared to offer adequate service. And so the circle of questions would begin again. What kind of staff do the clinics need? What should be the training of the psychiatrists and social workers? What kind of cases should be accepted? What kinds of service should be given? What should be the function of the social worker? What the content of the clinics' educational program? Agreement on one question pointed up difficulties on another. If, for instance, the staff of a clinic agreed that the most hopeful field of work

lay with children of adequate intelligence referred by their own parents, such questions immediately arose as who would undertake treatment in such cases, was the staff equipped for direct therapy with children, how many children could be treated in a year, is there any evidence that treating such children would reduce hospital admissions, and so on. If it was suggested that the work could be broadened without great expense by enlarging the clinic's case work staff, many of the same questions came up again, and in addition there was discussion of the place of the social worker in a program of psychotherapy.

A SUGGESTED APPROACH TO A RESOLUTION OF THE DIFFICULTIES

Consideration of the work and the difficulties of the clinics, their doubts and self-criticism, and the attitudes of representative individuals toward them led to the conclusion that many problems disappear when the clinics can clearly set forth, for themselves and for the community, their conception of their function. The proper sphere of activity of any social institution can be determined only by reference to its objectives, and it is here that there seems to be an implicit difference of opinion among directors of clinics. It has been shown that most state hospitals and schools for the feeble-minded originally undertook outpatient services in an effort to reduce the number of admissions to the institutions. Somewhat similarly, the early impetus to juvenile court clinics and to the visiting teacher movement was the hope that through early detection and treatment there would be a marked reduction in delinquency and crime. The clinics of the institutions for the feeble-minded seem to have been able, for the most part, to adhere to their original objective. This, it would seem, follows naturally from the problem they set themselves. Most feeble-mindedness is a definite characteristic that

can be recognized at an early age and that persists throughout life. It is true that the feeble-minded differ widely in the cause and degree of their disorder, in their personal characteristics, and in their capacity for being educated. But in this type of patient there is relatively little question as to whether the presence of certain symptoms at one age indicates the likelihood of other symptoms developing at a later age, which is the chief question in attempting to choose among children those who will later become psychotic or delinquent. The feeble-minded can be recognized early, and measures looking to their later self-sufficiency can be instituted in a certain proportion of cases. To do this requires a theory of education and treatment, a trained staff, adequate equipment, and a favorable attitude on the part of the public in general and the patients' relatives in particular. But in such favorable circumstances it seems likely that the institutions' objective of reducing the number of inpatients can be attained.

With clinics that aim at the reduction of admissions to state hospitals and penal institutions the situation is different. The objective here tends to shift from avoidance of institutionalization to prevention of the condition itself. In outpatient clinics for the feeble-minded the objective is the amelioration of the effects of a condition which itself is more or less static. In contrast, psychiatric clinics for children, at one stage of their development at least, seek to discover and treat in their patients not a disease or a defect but a psychological process that they believe may, if unaltered, lead to psychosis or crime. The change in the state hospitals' position (and it is there that the contrast is most marked) can easily be traced historically. Attention was at first concentrated on patients who had wholly or partially recovered; then on adults suffering from incipient mental disorder. The next group to be offered service were the children with extreme mental or neurological defects, who were clearly potential institutional charges un-

less their parents could be given some help with their care and training. Then, when closer study of the adult patients' histories showed that the course of mental difficulties was frequently traceable to childhood, the objective subtly shifted to prevention rather than (or, at least, in addition to) caring for patients who already showed signs of mental disorder.

With that shift came the important question whether the potential psychotics can be recognized in childhood. It is clear that to predict psychoses, to choose from among a group of children those who, if not treated, will later develop mental disease is a quite different matter from seeing in retrospect that certain mental patients led unsatisfactory lives as children. The little material that has been accumulated in answer to this question will be reviewed in another chapter. The point to be noted here is that when the clinics broadened their objective to one of prevention in childhood they began to accept as patients (in fact, to stimulate their referral) children of normal intelligence whose behavior was not considered by the public to be due to mental derangement. With a theory that prospective mental disease might be evidenced by either marked shyness, withdrawnness, and submission, or by marked aggressiveness in its numerous forms or, in fact, perhaps by any departure from the generally accepted average, the clinics began to study children of many types. In studying them it is doubtful whether much progress was made in answering the question of predicting psychoses but it did become increasingly clear that, potential psychotics or not, many of these children were in real need of some kind of psychiatric help. And thus the clinics came to another objective: that of promoting mental health for its own sake and not merely in order to reduce the number of institutional patients.

There seem, then, to be three more or less distinct aims that may determine the policy and function of a children's clinic: to reduce the number of admissions to institutions by

offering help in regard to the care and training of those children who would otherwise need institutionalization; to prevent the development of psychoses or crime in children whose behavior and personality traits suggest that they are headed in that direction; to give psychiatric assistance to children who need and desire it, regardless of whether they are potential psychotics or criminals or not. Each of these aims requires a more exact definition of the types of children to be served. There seems to be rather general agreement on this point in regard to the first aim. Under it come the feebleminded and the children suffering from neurological handicaps or other difficulties primarily of a physical nature. It is widely held that these children need psychiatric as well as psychological and physical examination, not only to determine their capacity for education, but to investigate the possibility that they may be suffering from emotional rather than (or in addition to) organic handicaps. Under the third aim the children to be served are largely those whom the community and their parents see as in need of help, and one of the tasks of psychiatry is to educate the professional public in regard to the symptoms and the situations it views as responsive to treatment.

Only the second aim raises difficult theoretical questions. Who are the potentially psychotic or criminal? Can they be identified in childhood and saved through preventive treatment? Whether the answer is yes or no, it is clear that a program of preventive psychiatry so conceived would place requirements upon the clinic program considerably different from those imposed by the other two aims. If this is so, it would seem to follow that a definition of function in accordance with one or the other of these three aims might clarify many of the difficulties of structure and service that were found to beset clinics.

Theoretically viewed, a clinic is a social institution—a set of beliefs, practices, materials, and values held by its staff

members and by the community in which it works. As such, its structure and its mode of operation become most efficient when they are derived directly and wittingly from the purposes they serve rather than forced to those purposes by outside pressures. Translated into practical terms this sociological dictum seems to mean that if a clinic will specifically define its function, answers to some of the questions of policy and structure will almost automatically appear.

Function—in the field of child psychiatry, at least—can be stated most succinctly in terms of scientifically designed aims. The types of patients to whom service is offered, the forms of assistance that are offered to them, the knowledge and skills required of the professional staff vary with the objectives for which clinics are established. There are, of course, some common principles underlying psychiatric work with all manner of patients; and, on the other hand, the means by which a given aim (especially that of promoting mental health) is to be carried out may be variously conceived. Nevertheless it seems to the writer that a first step toward clarification is made when a clinic can say specifically what it considers its main objective. The remaining chapters of this book proceed upon that assumption. The three aims which have been found to motivate clinic work will be separately examined, and their influence upon policy and practices will be considered, material for the discussion being drawn both from this investigation and from the current literature of psychiatry, psychology, and social case work.

CHAPTER TEN

Prevention of Psychosis and Crime as a Clinic Objective

IT has been shown in earlier chapters that historically and currently the hope of reducing the number of persons who must be cared for by state institutions, particularly mental hospitals, has been one of the chief motivations to the establishment of state-financed psychiatric services for children. For that reason mental hospitals first opened outpatient departments in which persons in what were considered the early stages of mental disease might receive help. Sometimes under the pressure of community demand and sometimes because of the hospital's changing conception of the evolution of mental disorders, children began to be admitted to these clinics. At first the children were those who appeared to have extreme mental defects or maladjustments, but gradually clinics began to offer their services to other types of children as well, usually on the theory that mental disease can be prevented only if it is detected in its earliest stages. Concurrently, the theory that delinquency and crime also can be anticipated and thwarted by psychiatric treatment gained favor among mental hygiene workers and by them was imparted to institutional administrators, court officials, and others concerned with such problems.

INCIDENCE OF PSYCHOSIS, DELINQUENCY, AND CRIME

That states spend large sums of money to provide institutions for the psychotic, the feeble-minded, and the delinquent is amply testified to by statistics. During 1933, the last year

for which detailed figures are available,¹ at least 400,000 people in the United States were patients of mental hospitals, and there were nearly 700,000² commitments to penal institutions; 68,000 children appeared on delinquency charges before 284 juvenile courts³ in 27 states, and 26,181 were committed to correctional institutions.⁴

Such figures, for obvious reasons, are very inadequate indicators of the amount of mental disease, crime, or delinquency in the country, since communities vary so greatly in their attitude toward and facilities to care for these groups. First admissions to state hospitals for mental disease, for instance, varied from 17.0 per 100,000 population in Colorado to 119.6 in Delaware, while, in Washington, D.C. (partly because of the presence of a large federal hospital that receives patients from outside the District) there was the high ratio of 178.1.⁵ The ratio of prisoners to the total population fif-

¹ The figures are given by United States government reports as follows:

Patients in hospitals for mental disease	
On the books, January 1, 1933	359,105
First admissions during year	69,368
Readmissions	17,039
Persons in all penal institutions (including jails)	
Present on January 1, 1933	233,631
Commitments during year	693,988

See *Patients in Hospitals for Mental Disease: 1933*, p. 2, and *Prisoners in State and Federal Prisons and Reformatories: 1933*, p. 1, U.S. Department of Commerce, Bureau of the Census, 1936.

² The reports make no attempt to say how many separate individuals were committed to penal institutions during the year.

³ These were the courts that reported to the United States Children's Bureau and included all the courts in Connecticut, Massachusetts, Rhode Island, Washington, D.C., and most of those in New Jersey and New York, and covered 30 per cent of the total United States population. *Juvenile Court Statistics and Federal Juvenile Offenders: 1933*, U.S. Department of Labor, Children's Bureau, 1936, p. 2.

⁴ *Juvenile Delinquents in Public Institutions: 1933*, U.S. Department of Commerce, Bureau of the Census, 1936, p. 3.

⁵ *Patients in Hospitals for Mental Disease*, op. cit., p. 19. Commenting on these figures, the report says: "Differences between States in the number of commitments to hospitals for mental disease per 100,000 of the general population, even when commitments to all hospitals are included, cannot be accepted as measuring accurately the existing differences between States in the prevalence

teen years old or older, on the other hand, was highest in Maryland (253.0) and lowest in New Hampshire (23.2), while Colorado occupied a middle position with a ratio of 118.5 per 10,000.⁶ In juvenile delinquency the variation was even greater. In Norfolk, Virginia, 507 per 10,000 boys appeared before the courts in 1933, and, in Montgomery County, Pennsylvania (the court with the lowest ratio), there were only twenty-nine.⁷

It is impossible to judge to what extent these variations are due to actual differences in the incidence of disease or offense, and to what extent to differences in manner of detecting, assuming responsibility for, and treating the individuals concerned. Since, however, the rate of first admissions to hospitals for mental disease was 89.6 per 100,000 in New York and but 31.3 in the not-so-different Pennsylvania, and that of boys committed to penal and correctional institutions 209.8 in Massachusetts and 503.4 in New Jersey (and only 22.8 in Idaho),⁸ it is clear that many factors besides magni-

of mental disease. Differences between States in the ratio of commitments to population are affected by differences in definition and diagnosis, differences in commitment laws and their administration, and differences in the extent to which hospital facilities are adequate. A low ratio in a State may simply indicate inadequate provision and a high ratio adequate provision for institutional care of mental patients.

"Doubtless there are real differences between States in the prevalence of mental disease. Real differences, where they exist, result mainly from such factors as differences in the proportion of the population living in urban areas, and differences in the sex, race, and age distribution of the population."

⁶ *Prisoners in State and Federal Prisons and Reformatories*, op. cit., p. 8.

⁷ *Juvenile Court Statistics and Federal Juvenile Offenders: 1933*, U.S. Department of Labor, Children's Bureau, 1936, p. 6. The report comments: "These rates are essentially a direct expression of the amount of delinquency dealt with by the courts that was brought to their attention by individuals and organizations concerned with the welfare and protection of both the children and the community. The rates of the courts are determined not only by the amount of delinquency in the respective communities served, but also by the policies of the police department and other agencies in referring cases to the courts, the intake procedure of the courts—particularly the extent to which they undertake to deal with minor cases—the relationship of the courts to other agencies in the community, and the extent to which the community provides services for children which tend to reduce the necessity for court action."

⁸ *Juvenile Delinquents in Public Institutions: 1933*, op. cit., p. 3.

tude of the problem go into producing the figures found in official reports. On the basis of such figures, however, it has been calculated that one out of every nineteen children born in New York State between 1929 and 1931 will become a patient in a mental hospital during his lifetime.⁹ No attempt at an estimate of the chance of being committed to a penal institution has been made, but it is obvious from the total figures it too would be high.

THE PROBLEM OF THE PREVENTION OF PSYCHOSIS

Faced with such figures, many institutional administrators found in the theory of early detection and prevention of later mental maladjustment a sound business proposition as well as a humanitarian appeal. Typical of this point of view is a statement in the first biennial report (1922) of the Pennsylvania Department of Public Welfare.

Mental clinics are one of the most important agencies for prevention of mental disease and defect, and the distressing complications so often met with, such as the various degrees of delinquency. Through the clinics, opportunity is afforded for that early consultation and advice in mental disorders and defect which often means avoidance of the necessity for institutional care and treatment. . . . Apart from the incalculable benefit arising to persons suffering from nervous and mental conditions, the activities of the clinics will mean a great saving to the taxpayers by reason of the prevention of considerable institutionalization and the quicker restoration of economic efficiency to many persons.¹⁰

Adolf Meyer, it has been indicated, was one of the early sponsors of the prevention theory, although even as he called attention to psychiatry's duty to "discriminate those traits of

⁹ "The Chances of Becoming Mentally Ill," *Statistical Bulletin*, Metropolitan Life Insurance Co., Vol. XVIII, No. 7 (July 1937), p. 5.

¹⁰ *First Biennial Report of the Secretary of Welfare for the Period Ending May 31, 1922*, Pennsylvania Department of Public Welfare, p. 25-27.

character that should serve as warnings to be heeded"¹¹ he was aware of some of the theory's limitations. Others, inclined to medical analogies, were more certain that the potentially psychotic could be identified. A recent commentator, for instance, says: "Certain oddities in childhood conduct may be the forerunners of a severe and chronic mental disease, just as certain physical signs . . . may be the first indication of a serious physical disease."¹² Most plans for state-supported psychiatric clinics for children more or less clearly anticipated, therefore, having two classes of patients—those who were readily recognizable as possible candidates for institutional commitment and those who displayed the types of difficulties that were believed to be predictive of later psychosis.

It is obvious, however, that very different questions of psychiatric theory and clinic practice are raised by these two groups of patients. In the first group are the incipiently psychotic, the feebleminded, the delinquent, and those afflicted with neurological disorders. Probably nobody would deny that many psychoses have a gradual onset and that persons in the early stages of the disorders can often be identified and sometimes cured. How frequently such conditions are found among children is, however, another question. Tests for feeblemindedness are well standardized and fairly valid. The presence of neurological disorders can be detected with a moderate degree of accuracy. Delinquency is legally defined, so it is relatively easy to say which child is a delinquent and which is not. Clinics that aim at the immediate reduction of institutional admissions would, therefore, logically concentrate their attention on these types of patients, and it has been

¹¹ Adolf Meyer, "What Do Histories of Cases of Insanity Teach Us Concerning Preventive Mental Hygiene during the Years of School Life?", *Psychological Clinic*, Vol. II (1908), p. 95.

¹² H. L. Levin, "The Role of Child Guidance in the Prevention of Schizophrenia (Dementia Praecox)," *New York State Journal of Medicine*, Vol. XXXIII (1933), p. 812.

shown that such is the practice—if not the specific policy—of many state-supported clinics. Others, however, incline to a long-time point of view and seek to prevent future maladjustments as well as to help present sufferers. Since this appears to the layman so reasonable a conception, accustomed as we are to the ounce-of-prevention theory in medicine, it seems best to discuss some of the questions involved in a preventive program before considering the implications of one that aims to keep children out of institutions.

The questions that need to be answered are three. Who are the potentially psychotic? By what signs are they to be identified; how can they be distinguished from other children? Second, is the theory of pre-psychotic characteristics substantiated by clinic experience? Third, what are the effects of the prevention-of-psychosis objective on clinic practice, on patients, and on the general public? To the practical person it would appear that if we have good reason to expect that certain children will later become psychotic it behooves clinics to see to it that they are treated. Such is the spirit—if not always the practice—of public health service and preventive medicine in general. Medical ethics allow the patient few choices if his life is at stake. We will later consider what modifications are imposed on these points of view by the very nature of the problems with which mental hygiene deals, but here at the outset it serves to highlight the importance of clarifying the prevention concepts if we realize what the community will expect if prevention of mental disease is promised.

Theories about the causes of mental disorders

Who are the potentially psychotic? Essentially, that is a question of the etiology of mental disorders, which can be further resolved into two questions: What are the causes of

psychoses, and what, if any, are their early signs? It is with the latter that we are concerned when we ask whether there are criteria by which the potentially psychotic can be identified, but it is from the former that much of the work that aims at prevention is derived.

It must be noted at the outset that there is a large group of psychoses in which the question of prediction in the early years of life cannot arise. These are the mental diseases which are due to intoxications, autointoxications, and such special diseases of the nervous system as general paresis, arteriosclerosis, and senile dementia.

Some of the theories with respect to the origin of the so-called functional psychoses have been described in Chapter I. Broadly speaking, four main points of view are current today. One school, following the Kraepelinian tradition, continues to seek for causes in underlying impersonal, organic processes and views the psychological symptoms of mental disease as of no particular significance etiologically. Another group of psychiatrists attempts to bridge the gap between organic and psychogenic theories by explaining the psychological aspects of mental disorders in dynamic terms. Schilder, for instance, says that he regards manic-depressive psychosis and dementia praecox as organic diseases, but that the desires and strivings that come to the surface in them (as well as in other psychoses, such as those caused by alcohol and drugs) represent an integral part of the personality. He sees an "inner connection between all the experiences in an individual's life" and, denying that reactions to early experiences are merely indicative of constitutional tendencies, holds that such experiences and the remembrances of them have definite formative value. The third point of view (that developed largely by Adolf Meyer) combines hereditary, constitutional, and environmental factors in a "psycho-biological" conception of mental

disease. C. Macfie Campbell¹³ has recently given an eloquent description of this interaction:

In discussing the role of the environmental factors . . . one must not forget that there are other things that try the soul of man besides external danger with the threat of annihilation; there are circumstances that destroy self-confidence, which foster a feeling of inferiority, which stifle independence, which give rise to a feeling of guilt, of inner corruption, of impending doom. . . . In tracing the development of a schizophrenic psychosis we see the individual with his own special constitution, moulded by his own unique life situation, passing into his schizophrenic experience not on account of cataclysms or catastrophes but under the joint influence of subtle pervading and continuously acting external factors and of the directing image of his inner goal.

The fourth, the strictly psychoanalytic theory of mental disease, differs from Meyer's chiefly in being more explicit about the mechanisms involved. It holds that "developmental and environmental factors in early childhood play a conspicuously important part in the development of psychoneuroses and psychoses,"¹⁴ but it too posits a constitution unusually susceptible to traumata. Fenichel,¹⁵ describing the schizophrenic process, for instance, says that it begins with a quantitative increase in the libido tension, which may be produced by various kinds of situations—by real disappointments, by circumstances stimulating the repressed infantile sexuality, by anything confirming infantile fears. This produces a revival and intensification of infantile sexual wishes, from which the ego protects itself by regression to narcissism. The etiology of the schizophrenic psychosis is therefore to be

¹³ Charles Macfie Campbell, *Destiny and Disease in Mental Disorders*, New York, W. W. Norton & Co., 1935, p. 197-98.

¹⁴ John Rickman, "The Development of the Psycho-Analytical Theory of the Psychoses: 1893-1926," Supplement Number 2, *International Journal of Psychoanalysis* (1928), p. 72.

¹⁵ Otto Fenichel, "Outline of Clinical Psychoanalysis," *Psychoanalytic Quarterly*, Vol. III (1934), p. 70-76.

found in the origin and nature of the narcissistic fixation and, theoretically, should be accountable for in terms of the quantitative relationship between constitutional factors and early experiences. He grants that information about both of these factors is unobtainable for the earliest nursing period, in which the basis for the psychosis is believed to be laid, and he says that there may be "no history of a single trauma in very early life but a series of general impediments in all vital activities."

Can future psychoses be predicted in childhood?

Since all of these theories attribute at least some causal significance to constitutional factors, there has long been considerable interest in the question whether persons who suffer from functional psychoses display in childhood any personality traits that distinguish them from normal individuals. In a certain sense the very attempt to find personality traits or other diagnostic signs by which the potentially psychotic can be recognized runs counter to dynamic psychiatry, savoring as it does of a theory of mental disease that "emphasizes a blind and fatalistic type of heredity and seeks most of the reasons for mental disease in the fixed constitutional make-up of the person."¹⁶ Nevertheless, interest in the question is not confined to the Kraepelinian school, with which it seems to have originated. Meyer's statement, cited a few pages back, is only one of many that could be adduced to show that others too think there is a possibility of discovering danger signals early in life.

Excessive sensitivity, seclusiveness, irritability, and occasional violent outbursts of temper are the most frequently cited childhood characteristics of the praecox patient, while the manic depressive is described as typically outgoing, emo-

¹⁶ Frederick H. Allen, "Prevention of Nervous and Mental Disorders in Childhood," *American Journal of Diseases of Children*, Vol. XXXVII (1929), p. 1260-61.

tionally unstable, and prone to excessive mood swings. Kraepelin,¹⁷ for instance, pointed out and cited others as finding that "in a considerable number of [praecox] cases definite psychic peculiarities have come under observation in our patients from childhood up." He said the male patients who were studied tended to have had as children a "quiet, shy, retiring disposition, made no friendships, lived only for themselves. Of secondary importance, and more in girls, there is reported irritability, sensitiveness, excitability, nervousness, and, along with these, self-will and a tendency to bigotry." In addition to these traits, the numerous investigators of the question of pre-psychotic personality have produced long lists of others which are held to be characteristic of these psychoses. Adolf Meyer¹⁸ in 1903 described the typical praecox patient as having been a "model child," particularly one that was meek rather than one that was good out of "strength of will." Later he elaborated this description by saying that the typical reaction of the praecox patient in childhood was "repression" and "depth of thought" in contrast to the aggressive mischief of the truant and the delinquent.¹⁹ Hoch²⁰ coined the term "shut-in personality" to describe the persons who "do not have a natural tendency to be open and to get into contact with the environment, who are reticent, seclusive, who cannot adapt themselves to situations, who are hard to influence, often sensitive and stubborn, but the latter more in a passive than in an active way. They show little interest in what goes on, often do not participate in the pleas-

¹⁷ Emil Kraepelin, *Dementia Praecox and Paraphrenia*, Edinburgh, E. and S. Livingstone, 1919, p. 236.

¹⁸ Adolf Meyer, "An Attempt at Analysis of the Neurotic Constitution," *American Journal of Psychology*, Vol. XIV (1903), p. 354-67.

¹⁹ Adolf Meyer, "What Do Histories of Cases of Insanity Teach Us Concerning Preventive Mental Hygiene during the Years of School Life?" op. cit. (n. 11), p. 89-101.

²⁰ A. Hoch, "Constitutional Factors in the Dementia Praecox Group," *Review of Neurology and Psychiatry*, Vol. VIII (1910), p. 463-74.

ures, cares and pursuits of those about them; although often sensitive, they do not let others know what their conflicts are; they do not unburden their minds, are shy, and have a tendency to live in a world of fancies." He found that over half of a group of more than a hundred schizophrenic patients were of this type. Bleuler reported that "in probably three-fourths of the dementia praecox cases the personal disposition already expresses itself during youth more in a dereistic character, inclined to seclusions, than in other peculiarities and deviations from normal thinking."²¹ In addition to these characteristics, later investigators reported inflexibility, inflated narcissism, anal-erotic traits, sexual imbalances and lack of sexual adaptability, unusual reticence, inadequate emotional reactions.²² So firm has become the belief of certain groups of psychiatrists in the peculiar pre-psychotic personality of the typical manic-depressive and dementia praecox patient that the differential diagnosis of the two diseases is frequently based upon such evidence.

Statistical studies aimed at testing these observations by comparison with control groups are handicapped by various considerations, among which the retrospective character of the personality descriptions is particularly important, especially for the psychotic group, since informants are prone either to minimize or to exaggerate the peculiarities of such individuals when they know their present mental condition. Probably the most extensive study of this type was made by a group of investigators at the Boston Psychopathic Hospital.

²¹ Cited by Karl Bowman and Alice Raymond, "A Statistical Study of the Personality in Schizophrenic Patients," *Schizophrenia: an Investigation of the Most Recent Advances*, Baltimore, Williams and Wilkins Co., 1931, p. 48-50.

²² These traits are among a long list noted by Newton J. T. Bigelow, "Pre-psychotic Personality of Catatonic Schizophrenics," *Psychiatric Quarterly*, Vol. VI (1932), p. 642-56; Joseph R. Blalock, "Personality and Catatonic Dementia Praecox," *Psychiatric Quarterly*, Vol. VI (1932), p. 625-41, and the study by Bowman and Raymond cited above.

The control group consisted of about a hundred social work students who rated themselves. Striking differences in the incidence of certain traits were found, the most outstanding characteristics of the dementia praecox group being their "close-mouthedness" (sixty-eight per cent of the 100 patients) and their extreme sensitivity (fifty-three per cent). These traits were also found, but not so frequently, among the manic depressives.²³ Comparison of other groups of schizophrenic and manic-depressive patients with those suffering from general paresis revealed that from a fourth to a half of the first two groups were considered normal in childhood as compared with about two-thirds of the parietic patients.²⁴ Clinic observers and statistical investigators seem thus to come to fairly similar conclusions that tend to substantiate the textbook descriptions of the characteristic personality traits of manic-depressive and schizophrenic patients. Similarly, it has been rather well demonstrated that many such patients come from emotionally destructive homes.²⁵

Although these retrospective studies about personality and home situations tend to uphold the theorists' expectations, it is equally noteworthy that all investigators found many patients whose histories did not conform to the usual pattern. Kraepelin²⁶ said only that a "considerable number" of patients had definite psychic peculiarities from childhood on and cited Karpas' and Schultze's figures of fifty to seventy per cent psychopaths, and Schott's statement that about twenty-

²³ Karl Bowman, "A Study of the Pre-psychotic Personality in Certain Psychoses," *American Journal of Orthopsychiatry*, Vol. IV (1934), p. 473-98.

²⁴ Bowman and Raymond, *op. cit.*, p. 52.

²⁵ Helen Leland Witmer and Students, "The Childhood Personality and Parent-Child Relationships of Dementia Praecox and Manic-depressive Patients," *Smith College Studies in Social Work*, Vol. IV (1934), p. 289-377. Included in abbreviated form in Ernest Groves and Phyllis Blanchard, *Readings in Mental Hygiene*, New York, Henry Holt & Co., 1936.

²⁶ Quoted by Bowman and Raymond, *op. cit.*, p. 48. Other statements in this paragraph are from the works of the investigators which have been previously cited.

eight per cent were quiet and reserved as children. Faver found that nineteen per cent of a group of catatonic patients had "no striking traits" in childhood; Blalock reported that sixty per cent of a similar group were active and lively as children; Bowman and Raymond rated from twenty-two to forty-two per cent of large groups of schizophrenic and manic-depressive patients as normal in childhood; and the conclusion reached by the Smith students was that not more than a third to a half of the patients had been markedly mal-adjusted as children, and that about half of them had homes that would not be expected to be unusually handicapping.²⁷ Kasanin and Veo²⁸ came to similar conclusions in a study in which the grammar and high school teachers of fifty-four schizophrenic and manic-depressive patients were asked what these people had been like as children. Half of them were described by the teachers as either "fairly well adjusted" or "outstanding leaders," and the writers say, "We do not see how in these children any question of mental disease can be raised." Less than a fourth were described as so unusually striking, odd, peculiar, queer that everybody noticed them, and these they conclude were already psychotic when in school. The final group (thirty-one per cent) were sensitive, shy, colorless children whom the teachers could barely recall. They gave no trouble and were not looked upon as problems.

Such findings make it doubtful that any large proportion of psychotic patients could have been identified in childhood as likely later to have a mental breakdown. In addition, all these studies are open to question because the informants knew that the individuals inquired about had become psychotic. A better test of the predictability of mental disorders was made in two investigations, in which the case records of

²⁷ Helen Leland Witmer and Students, *op. cit.*, p. 339-356.

²⁸ Jacob Kasanin and Louise Veo, "A Study of the School Adjustment of Children Who Later in Life Became Psychotic," *American Journal of Orthopsychiatry*, Vol. II (1932), p. 212-27.

mental patients who had been examined in a child guidance clinic as children were studied. Kasanin and Veo²⁹ found among the patients of the Boston Psychopathic Hospital eight persons who from two to eight years earlier had been examined at the Judge Baker Foundation, and Mooney³⁰ found ten in the Cook County Psychopathic Hospital files who had earlier been patients of the Illinois Institute for Juvenile Research. Perhaps the most striking thing in both investigations is that so few child guidance patients later became hospital patients—for through these two hospitals probably the majority of the psychotic patients of Boston and Chicago pass. Both clinics had been in operation for many years when the investigations were made, so the age factor did not seem a sufficient explanation of the low numbers. It seemed either that the clinics prevented psychoses or that they did not receive as patients the kind of individuals who are apt to become psychotic later. However that may be, the main findings of the studies were that these patients as children did not show symptoms that differentiated them from other problem children and that in only three cases (in two of which the patients were doubtless already psychotic) did the examining psychiatrists note the presence of symptoms which they recorded as being prognostic of later mental disease. In other words, it appeared that even among child guidance clinic patients those headed for mental disease cannot be identified unless they have already advanced to the early stages of a psychosis.

The argument that psychoses can be prevented through

²⁹ Jacob Kasanin and Louise Veo, "The Early Recognition of Mental Diseases in Children," *American Journal of Orthopsychiatry*, Vol. I (1931), p. 406-29. See also Louise Veo, "A Personality Study of Six Adolescents Who Later Became Psychotic," *Smith College Studies in Social Work*, Vol. I (1931), p. 317-63, for a further description of the same cases and a rather different interpretation of findings.

³⁰ Marjorie Mooney and Helen Leland Witmer, "Ten Problem Children Who Later Became Psychotic," *Smith College Studies in Social Work*, Vol. III (1932), p. 109-50.

the early identification of potential psychotics by means of their personality traits is, however, open to even more serious question. It is one thing to demonstrate that a certain proportion of psychotic adults showed characteristic symptoms or lived under peculiarly handicapping conditions as children. It is an entirely different one to maintain that the presence of these traits in a child marks him as one who is apt to develop a psychosis. This, however, is the almost necessary assumption of a prevention-of-psychosis program. There seem to be only two possible alternatives to that point of view. If it does not maintain that the children particularly liable to a psychosis can be identified, then a clinic that justifies its work on the basis of prevention of psychoses would have to believe that a large proportion of problem children are especially prone to future mental disorders. The only other alternative lies outside the clinical field and consists in working for the general amelioration of conditions which are considered productive of mental disorders.

No studies adequately testing the first alternative have been made, since such an investigation would necessitate the clinic examination of large groups of children and periodic check-ups on their later adjustment. What partial approaches to an answer have been made suggest, however, that the proportion of child guidance patients who subsequently are found to be extremely maladjusted is not large. A follow-up study of 197 patients of the Institute for Child Guidance, New York, one to three years after the cases were closed showed that only sixteen were adjusting extremely poorly. Twenty-five per cent of the children were nineteen years of age or older when the follow-up investigation was made; fourteen per cent of these children were adjusting very poorly.³¹

³¹ Helen Leland Witmer and Students, "The Outcome of Treatment in a Child Guidance Clinic," *Smith College Studies in Social Work*, Vol. III (1933), pp. 390, 393. Numerous other follow-up studies made by students from Smith College School for Social Work in other clinics came to very

A more specific approach to the question of whether psychoses can be predicted in childhood is offered by follow-up studies of children who show traits that are in keeping with those considered as characteristic of psychotic patients as children. Excessive daydreaming and seclusiveness form one such group of traits, as noted above. Walcott,³² studying the adjustment of seventeen such children two to eight years after they had been examined by the Institute for Juvenile Research, reported that only three were markedly maladjusted and none was psychotic. All but two of these patients were from fifteen to twenty-five years old when the follow-up study was made. "Neurotic" children are another group for whom the prognosis might be believed to be poor. Karlin and Markus³³ report a follow-up study of thirty out of fifty such cases diagnosed at the Michael Reese Hospital, Chicago, as suffering from psychoneurosis, emotional instability, emotional infantilism, or marked feelings of inferiority. The follow-up study was made three to five years after the children were examined at the hospital, when eleven of the children were over sixteen. At that time seven were still seriously maladjusted and two were psychotic.

Even more directly related to the question of predicting psychosis is Yauger's³⁴ follow-up study of forty-four children who between 1923 and 1927 had been described by examining psychiatrists at the Illinois Institute for Juvenile Research as having schizoid tendencies, being possibly schizophrenic, or in the early stages of dementia praecox. Eight

similar conclusions. See "The Later Social Adjustment of Problem Children: a Report of Thirteen Follow-up Investigations," *Smith College Studies in Social Work*, Vol. VI (1935), p. 1-98.

³² Esther Walcott, "Day Dreamers: a Study of Their Adjustment in Adolescence," *Smith College Studies in Social Work*, Vol. II (1932), p. 283-335.

³³ Edith Karlin and Laretta Markus, "Neurotic Children," *Smith College Studies in Social Work*, Vol. VI (1935), p. 78-83.

³⁴ Muriel Yauger, "Child Guidance Patients Diagnosed as Possibly Suffering from Dementia Praecox," *Smith College Studies in Social Work*, Vol. VI (1935), p. 84-90.

were less than twelve years old when examined. The group was described as very much withdrawn, lacking in affect, having violent temper tantrums or definite psychotic symptoms. Only two children received extensive treatment at the Institute. Six to ten years later, when most of the patients were twenty-one to thirty years old, only ten (twenty-three per cent) were psychotic (six of them being diagnosed dementia praecox) and fifteen (thirty-four per cent) were described as being very well adjusted. This latter proportion is not significantly lower than that which follow-up studies of other groups of problem children have revealed.⁸⁵

The crucial test for prediction theories would be, of course, to follow for a long period (but not treat) a group of children who had the characteristics considered prognostic of mental breakdown. In the absence of such a study (and the difficulties that stand in its way are numerous, not least of which is that competent observers would probably be unwilling to refrain from offering aid to such children) all of the other approaches to the problem suggest that it is probably impossible, except in a small proportion of cases, to say which children are later apt to become psychotic.

That conclusion does not seem to be out of keeping with the psychogenic theory of psychoses. Schilder has pointed out that though the absolute necessity of a neurotic symptom becomes obvious when we examine a case, it would be impossible to determine beforehand that a symptom has to appear.⁸⁶ Rickman's⁸⁷ discussion of prophylaxis through the treatment of psychoneurotics is doubtless equally applicable to problem children. He says:

⁸⁵ Helen Leland Witmer, "A Comparison of Treatment Results in Various Types of Child Guidance Clinics," *American Journal of Orthopsychiatry*, Vol. V (1935), p. 351-60.

⁸⁶ Paul Schilder, "Psychoanalysis and Philosophy," *Psychoanalytic Review*, Vol. XXII (1935), p. 283.

⁸⁷ John Rickman, *op. cit.* (n. 14), p. 72-74.

It is commonly believed that by treating psycho-neurotics it is possible to do sound prophylactic work in reducing the number of psychotics; psychoanalysts do not share this belief, not because it is in itself incredible but simply that it requires proof or at least some explanation. The first question that has to be decided is whether the mere presence of a mechanism that is found in psychotics is to be regarded as a sufficient justification for thinking of the case as potentially psychotic. The answer is in the negative for two reasons, first, because a mechanism is a device for reducing painful tension in the mind, it is not even a pathological process but is sometimes brought into action on account of one; and, secondly, because to lay stress on this or that mechanism obscures the importance of quantitative elements. . . .

We are unable . . . exactly to say what is a pre-psychotic condition and must turn on those who profess to deal prophylactically with a condition they have not defined and ask them for their evidence.

He continues his explanation by saying that there are three main causes of functional mental disorders. In some cases the external world fails to provide the satisfactions that the individual needs. In others the patient falls ill because his inner requirements prohibit gratification. And, finally, there are some persons who can tolerate only a certain amount of frustration. To predict whether a given individual will fall ill if his libido tension increases beyond its accustomed degree, it would be necessary to know (1) his sublimation capacity, (2) the degree of character change that is possible, and (3) the possible channels for the outlet of his libido gratification. These, it is clear, are imponderable, and so he concludes that prediction of mental disease is usually impossible.

By this devious route, then, we come to a probable negative answer to the question of whether there is much likelihood that potential psychotics can be selected in childhood for preventive treatment. This conclusion is in keeping both with modern theory, which discredits the fatalism of pure consti-

tutional causation, and with modern practice, which finds the dynamic agents of therapy in external circumstances and personal relationships as well as in inner capacities for growth. If, then, psychoses can be prevented through child guidance only in the sense that out of the large number of children who are brought to the clinics for help there are some (a usually unrecognizable group) who will eventually "escape into psychosis" if they do not find aid there or elsewhere, it would seem that the aim of the prevention of psychosis must be abandoned as a primary objective of child psychiatry. Nevertheless, even if a modern theory of psychiatry that makes the prediction of psychosis impossible supplants the earlier one that held psychoses to be almost inevitable in certain types of patients, the point of view of Adolf Meyer,³⁸ expressed years ago, still holds:

To those who think that it is scarcely worth while to trouble ourselves over the few who would fall by the wayside anyhow, I can address no stronger plea than to urge that what often leads to complete breakdown in some will partly spoil the life of others or at least seriously interfere with their success.

Adverse effects of the prevention-of-psychosis objective

Since psychiatric theory and clinic experience lead to the conclusion that prevention of psychosis through the treatment of problem children is at best a kind of "shot-gun" approach, the further disadvantages of such an objective can justifiably be considered. Its ramifications appear to be numerous, affecting the attitudes toward the clinic of the general public, the professional groups, the patients and their families, and the clinic staff itself.

Most psychiatric clinics for children hold that a necessary part of their work is the education of the lay and professional

³⁸ Adolf Meyer, "What Do Histories of Cases of Insanity Teach Us Concerning Preventive Mental Hygiene during the Years of School Life?" op. cit. (n. 11), p. 97.

public. This usually includes general lectures, perhaps newspaper and radio publicity, as well as the more specific instruction that is given by means of mental hygiene courses and conferences in regard to specific cases. The clinics that do not engage in such activities rely upon the public's prior understanding of psychiatric work or believe that the value of the clinics will be self-evident. To the public, clinics almost necessarily have the same connotation as their sponsoring bodies, and, since these are chiefly mental hospitals, the public naturally regards the work of the clinics as closely connected with mental disease, work that is necessary but definitely unpalatable. Such attitudes, rather than being modified, are probably reinforced by the clinics that engage in educational programs if the emphasis in their talks is laid upon the clinics' interest in preventing psychoses through the recognition of early symptoms. The attempt to make the public "schizophrenically minded,"³⁹ to engage in anti-psychosis campaigns may well have many unintended consequences. It may put into the hands of lay persons weapons, in the form of diagnostic criteria, that can be used very destructively. It may reinforce the stigma that the public already attaches to all things psychiatric. It may increase the anxiety of the already anxious and foster the attitudes of overconcern which it aims to modify.

The chief teaching of such an educational campaign is that certain traits of character—particularly marked sensitivity, seclusiveness, irritability, mood swings—may indicate that a child is headed for a psychosis unless he is given psychiatric help. In addition, the adverse influence of certain types of parental attitudes is generally pointed out, and the overprotective mother and the one who does not sufficiently love her children, for instance, are accused of fostering emotional patterns that may lead to mental breakdown. Few

³⁹ H. L. Levin, *op. cit.* (n. 12), p. 812.

clinicians would state the propositions so bluntly, but it is into some such words that many laymen would translate what they are taught.

Such generalizations confirm what the public already is inclined to believe—that children whose behavior differs from that of the majority are “not quite right.” They give to teachers, social workers, judges, probation officers and the like some prognostic criteria that enable them to affix labels to children and so avoid viewing them as individuals. What the effect of the label will be upon the professional person’s attitude toward the child will vary with his own propensities. He may attempt to shield and favor the child or he may be repelled by him. Whatever the attitude, it will carry with it the individual’s feeling about mental disease and it is not very apt to be helpful to the child. Judges and social workers may be sustained in their conviction that stern measures must be taken to remove children from the adverse influences of their parents. Teachers may put forth great efforts to make the shy child gregarious or to force the sensitive one to overcome his fears. These practices are probably natural concomitants of popularized mental hygiene but they acquire additional vigor when they are backed by the conviction that only through some such measures will a child be saved from eventual mental breakdown.

With the patients and their parents the effects of a clinic program that is publicly directed toward the prevention of mental disease may be even more unfortunate. Parents are typically insecure and anxious about their children and eager for them to conform to accepted standards. The very attitudes which are considered handicapping to a child’s emotional development may well be enhanced if the parents learn that certain behavior on the part of children augurs ill for their later mental health. Such knowledge can confirm hostile parents in their attitudes toward the children who thus

disgrace them, can increase the guilt of those who feel they are to blame, and can lead the anxious ones to increase their protectiveness. Many parents already consider it a disgrace to have to seek psychiatric help for their children, especially when it is given under the auspices of a mental hospital. Their unwillingness to use the clinic would obviously be increased if both they and their neighbors knew that the clinic's function was to prevent mental breakdown. The patients too, even though they are young, are apt to have definite convictions about "doctors who examine your head," and their anxiety about going to a clinic may well be increased if the people who take them there also associate the clinic with psychosis.

Perhaps even more important is the influence that the prevention-of-psychosis theory may have on the attitudes and practices of the staff itself, for by it all manner of extreme measures may be justified. A staff that thinks in such terms is apt not to possess a very refined psychiatric technique but to be inclined to rather straightforward measures of advice and authority. The honest conviction that extreme oversolicitude on a mother's part, for instance, may lead her son to schizophrenia may make a well-meaning staff advise the break-up of the home. Since patients are rarely seen by the psychiatrist more than once and the work of carrying out the recommendations of the clinic is left in local, usually untrained hands, the possibility of doing damage through attempting to rearrange the lives of others is enhanced. For it is difficult to caution the local workers to be tolerant and at the same time teach them that the dangers are great.

Finally, if it is true that both experience and theory lead to the probable conclusion that no great decrease in mental disease is to be anticipated by a child psychiatry program, the more important work of promoting and preserving mental health is apt to be handicapped by false promises. The prevention slogan tends to bring to the clinics the types of pa-

tients who are already beyond the possibility of being helped, especially when the help must be given under the conditions prevailing in most traveling clinics. This in itself is not a good advertisement for a clinic. It strengthens the public's scepticism about the value of psychiatry, and it increases the stigma attached to attendance at the clinic. In addition, the failure of a clinic to reduce the psychosis rate must ultimately be apparent. Some statistically minded administrator or politician will someday ask for an accounting, and the program that bases its claim to public support on an untenable preventive aim is likely to be abolished.

Summary of the argument

A plan for preventing psychoses through the treatment of children who are likely to develop serious mental disorders falls down, then, for various reasons. In the first place, psychiatrists disagree as to the causes of the functional psychoses. The psychoanalytic and other dynamic theories, emphasizing as they do psychogenetic factors, offer greater hope than the others for prophylactic work in this area, but they give little support to the belief that the relative strengths and weaknesses of a child's personality can be so assessed that the likelihood of his developing a psychosis can be estimated. Then, on the factual side, there is little to substantiate the belief that the findings with respect to pre-psychotic personality traits are reversible. On the one hand, there are large numbers of psychotic patients who as children appeared, according to all reports, to have been normal. On the other, even if it is granted that children with certain personality traits are more likely than others to develop mental disorders, there is nothing to indicate how much greater that likelihood is, nor does the little evidence available suggest that it is excessive. Accordingly, a mental hygiene program aimed at identifying the potential psychotics among school children would

locate only a certain proportion of them at best and would expend much effort upon a group whose chance of mental disease is slight. In addition, such a program, by picking out the ones already handicapped emotionally, might well prove definitely harmful to them by increasing their anxieties and confirming the community's suspicion that they are "queer." It would seem, then, that the direct prevention of mental disease is not a satisfactory objective, since that point of view tends to alienate the very groups that it would help and fosters attitudes of fear and suspicion that are most unhygienic mentally.

THE PREVENTION-OF-DELINQUENCY OBJECTIVE

The case for and against the prevention of delinquency and crime through psychiatric clinics for children is a rather different story. Here the etiological theories have been somewhat more satisfactorily worked out, and the dangers involved in singling out children for treatment are not so great, since "pre-delinquents" are somewhat more readily identifiable on the basis of behavior that the community is already concerned about. In addition, the concept, delinquency, does not carry with it the emotional overtones that psychosis does, so that a proposal to prevent delinquency would probably find parents and teachers in a more accepting mood. Nevertheless, there are difficulties that stand in the way of such a program as well. Not the least of these is that it—like the prevention-of-psychosis objective—focuses attention upon future possibilities rather than upon present needs and so tends to stigmatize the children whom it would serve. Then, too, it imputes to psychiatric treatment a kind of immunizing against future contingencies that is not substantiated by any psychiatric theory. Finally, a prevention-of-delinquency program tends to assign to the psychiatrist the function of the policeman. Psychiatry cannot take upon itself the responsi-

bility for altering the conduct of its patients, since the chief tool of its trade is a non-condemning attitude. Many of the difficulties of preventing delinquency through psychiatric treatment grow out of this fact. As White pointed out, it makes no difference to the community what a man thinks or what he suffers mentally. It is his behavior that counts.⁴⁰ Dynamic psychiatry, however, is held by many to be chiefly concerned with feelings rather than with behavior. The relinquishing of socially disapproved modes of behavior may be a hoped-for by-product of psychiatric treatment, but it cannot be its direct objective. Nor is this apt to be the result of psychiatric treatment unless the behavior itself is the result of psychological stresses. Since much delinquent behavior is a reaction to social pressures and deprivations, psychiatry can aid in the prevention of delinquency only in so far as it can help to remove those obstacles or help its patients to find compensations for them. The former, in many cases, is a hopeless task and the latter may be undesired by the patients. The question of the extent to which a psychiatric clinic may be expected to aid in the prevention of delinquency becomes one, then, of attempting to estimate the extent to which delinquency is due to psychological causes.

Delinquency is a legal rather than a psychological category, the counterpart of the term insanity as compared with psychosis. White⁴¹ points out that the insane are a class of people with certain symptoms or types of conduct, usually socially destructive in nature. To call a person insane, he says, "gives no more specific information about the individual than would the terms fever or cough if they were similarly applied." So it is with delinquency. It gives no indication as to the cause of the child's behavior but only denotes that he has

⁴⁰ William A. White, "Underlying Concepts in Mental Hygiene," *Mental Hygiene*, Vol. I (1917), p. 7.

⁴¹ *Ibid.*, p. 7.

committed certain acts which are forbidden by law. In addition, the strict definition of the term requires that these acts shall have brought the child before a court. It is a commonplace that the likelihood that a given offense will lead to court action varies with the economic position of a child's parents and the kind of community in which the offense takes place. A recent study has made this more explicit by showing that even among social groups of broadly similar economic and social standing there are greater differences in the amount of delinquency than in the number of problem children. These "reflect chiefly the different customs regarding children and resources for their care. . . . Differing behavior on the part of parents and authorities [with respect to the use of courts and social agencies] may be as much a modifier of neighborhood rates [of delinquency] as different proportions of troublesome children."⁴²

A program aimed at the prevention of delinquency thus reaches after an elusive thing. Delinquency rates may go down and yet the size of the problem remain constant. The figures cited at the beginning of this chapter, which show that fairly similar states have widely different crime and delinquency rates, testify to that possibility. The situation with respect to measuring the incidence of mental disorders by hospital admissions is similar to this, but only superficially so. Psychotic individuals are mentally disturbed whether they remain at home or are committed to hospitals. Children are delinquents, however, only if certain activities are forbidden. If school attendance is not compulsory, there are no truants. When apples are found on trees rather than on pushcarts, stealing a few is not apt to precipitate court action. If there are opportunities for the outlet of high spirits and youthful energy, fewer children will come in conflict with the law. In

⁴² Sophia Moses Robison, *Can Delinquency Be Measured?*, New York, Columbia University Press, 1936, p. 4.

other words, delinquency involves social customs as well as individual activities. It is not a purely intra-psychic phenomenon.

Theories about the causes of delinquency

Numerous theories as to the causes of delinquency and crime have been advanced since Lombroso, in the middle of the nineteenth century, proposed the study of the criminal instead of the crime. He, a physiologist and psychiatrist, sought to prove that the criminal is an abnormal person, distinguished chiefly by a reversion to a more primitive physiological structure. Finding this theory of atavism not wholly satisfactory, he added the concept of moral insanity and later held that most criminals are epileptics. In addition to these born criminals, he recognized various other types—criminals by passion, insane criminals, and criminals who have drifted into their way of life because of faulty education, evil associates, or unfavorable social environment. Ferri and Garofalo built upon and modified these theories. The first emphasized the numerous factors that enter into crime, and the second elaborated upon the abnormal nature of the criminal. Although, by their insistence on abnormality, these and other theorists in the so-called anthropological school gave little hope for understanding or reforming the criminal, they did a service in removing crime from the field of moral perversity. By their admission, even when most seeking for abnormality, that criminals range in degree and that some cannot be distinguished from the normal, and by their insistence that untoward circumstances as well as abnormal personality play a part in the production of crime they laid the basis for other ways of viewing delinquency.

The interpretation of crime as a social phenomenon and the criminal as the product of adverse social conditions was the contribution of another group, the most prominent early

writers being Tarde and Durkheim. The theory reached its climax among the so-called socialist criminologists, of which Bonger of Germany was perhaps the most outstanding representative. In the United States the theory furnished the impetus for numerous descriptive and statistical studies, especially in regard to juvenile delinquents. These investigations have sought to show that delinquency is attributable to one or more of a host of adverse social factors: broken homes, poor physical surroundings, criminal antecedents, neighborhood deterioration, foreign-born parents, lack of parental supervision, inadequate recreation, too early employment, and so on—in other words, to poverty and its associated conditions.⁴³

When adequate control groups have been used, however, it has been found that, like Lombroso's physical stigmata, many of these handicaps taken individually do not differentiate the delinquents markedly from other children. One large study showed that broken homes are only slightly more frequent among delinquents than among other children of the same age and national background who live in the same areas.⁴⁴ Another found delinquents somewhat inferior in "verbal abstract intelligence," but in "non-verbal concrete intelligence" much like their neighbors,⁴⁵ while a third investigator discovered that in mechanical ability they were well above the average.⁴⁶ Another investigation of large numbers of cases revealed that delinquents are no more retarded in school than

⁴³ The literature on the causes of delinquency and characteristics of delinquents is very large but has been well summarized by Walter C. Reckless and Mapheus Smith in *Juvenile Delinquency*, New York, McGraw-Hill Book Co., 1932.

⁴⁴ Shaw and McKay, "Social Factors in Juvenile Delinquency," *Report on the Causes of Crime*, National Commission on Law Observance and Enforcement, Washington, D.C., 1931, Vol. II, Number 13, p. 276.

⁴⁵ John Slawson, *The Delinquent Boy*, Boston, Richard G. Badger, 1926, Chapter II.

⁴⁶ Butcher, Hoey, McGinnis, *A Study of Problem Boys and Their Brothers*, Albany, New York Crime Commission, Sub-Commission on the Causes and Effects of Crime, 1929, p. 12.

other children who live in similar neighborhoods.⁴⁷ Even the association of delinquency with poverty has been questioned.⁴⁸

It may be, therefore, that delinquency is largely an artifact, reflecting variations in social custom, or it may be that it is the form that behavior deviations are apt to take under the influence of poverty.⁴⁹ This latter formulation has been variously elaborated by sociologists and psychiatrists. The former maintain that poverty and its social correlates—inadequate housing, malnutrition, inadequate recreational facilities, lack of parental supervision—provide a setting favorable to the creation of anti-social ideals. The exploits of gangsters, the success of underworld activities, the contrast between opportunities and the standards of success set up by a competitive, individualist society create cultural values that, although not given official sanction, are nevertheless motivating forces in the lives of children of the slums. Clinic practice seems to confirm sociological theory in this area. Some clinicians go so far as to question whether some delinquents are maladjusted at all, whether the maladjustment is not in the society which rewards and praises economic success and offers so little opportunity for attaining it.

Psychoanalytic theory, on the other hand, provides another way of viewing the possible influence of poverty on a child's

⁴⁷ J. B. Maller, "Juvenile Delinquency in New York City," *Journal of Psychology*, Vol. III (1936), p. 7.

⁴⁸ Sophia Moses Robison, *op. cit.*

⁴⁹ Some substantiation of this latter point of view has been provided by studies that compare the types of problems presented by children referred to visiting teachers in economically different sections of a city. A study by Helen Trolan dealt with the children referred over a six-year period to the Child Guidance Department of the Newark, N.J., public schools by a school in a residential area and one in a very poor section of a city. With age, sex and intelligence held constant, it was found that in the poor district the children were predominantly referred because of anti-social behavior while in the other most of them had "personality difficulties." Another investigation conducted by Dorothy Hayes in two unlike school districts in Rochester, New York, had similar findings. Unpublished theses on file in Smith College Library: abstracted in *Smith College Studies in Social Work*, Vol. IV (1933), p. 166, and Vol. VIII (1937), p. 118.

emotional development. It is its fundamental thesis that social adjustment represents the curbing or sublimating of instinctual tendencies for the sake of avoiding pain of punishment and loss of love and of gaining various forms of social rewards. This balance between gratifications and renunciations is the less stable the more the restrictions and denials the individual has to endure. On the realistic side it is obvious that the children of the poor are subjected to unusual strains. As Alexander says, "To renounce personal freedom for nothing is evidently more difficult than to renounce it in order to get something in exchange. Therefore, the original unadjusted nature of man is more apt to break through and to overthrow social restrictions in the discontented strata of the population."⁵⁰ But poverty, according to the psychoanalysts, is not in itself a sufficient explanation of delinquency. Constitutional and dispositional factors must also be taken into account, and the personal influences of the various family members are particularly important. Elaborating upon these from his analytic studies of a group of young criminals, Alexander comes to the following conclusions:

We have found that criminal behavior in the majority of cases is the expression of a protest against certain deprivations, a reaction of spite against certain members of the family, the expression of jealousy, envy, competition, and frequently a proof of masculinity. Often it originates from the stubborn wish for compensation for previous deprivations, or is the result of a sense of guilt and consequent need for punishment, similar to that found in the psychogenesis of neuroses. . . .

The only difference which our investigation up to now was able to establish is the greater tendency of the criminal personality to rationalizations. . . . In addition to the greater tendency, there is also a greater opportunity for rationalization which is inherent in the social situation. In cases where actual deprivations due to

⁵⁰ Franz Alexander, "Contribution to Psychological Factors in Anti-Social Behavior," *The Family*, Vol. XIII (1932), p. 143.

social circumstances are present, these latter can easily replace previous emotional conflicts arising from the family situation. . . . If the social situation gives justified reason for discontent and anti-social attitude, the early emotional conflicts in the family are more likely to be worked out on the social level, and the earlier discontent from the family situation together with the social discontent are more apt to lead to non-social behavior than to neurotic symptom-formation.⁵¹

On the other hand, he holds that it would be "erroneous to deny the reality and importance of the more tangible conscious conflicts deriving from the actual situation and to consider them always as mere excuses for relieving unconscious aggressions in the form of anti-social behavior. In some cases these actual social conflicts alone suffice to explain non-social behavior."

A recent study by Healy and Bronner⁵² gives statistical and clinical corroboration to this social-psychological point of view and probably best represents the current position of child psychiatrists. Comparing 105 delinquents with siblings of much the same age and sex distribution, they found the two groups very similar in health and intelligence but very different in personality. Nearly two-thirds of the delinquents (as compared with about ten per cent of the siblings) were described as "active, restless, energetic, and rather uninhibited," many of them exhibiting these traits to a marked degree; but a "large majority of both groups were not recognized as presenting anything but normal emotional poise."⁵³ Interest in clubs, sports, reading, and movies was more prevalent among the delinquent than among the non-delinquent group. An enormous difference between the two groups was found, however, in the incidence of "profoundly felt emotional disturbances."

⁵¹ Ibid., p. 145-46.

⁵² William Healy and Augusta Bronner, *New Light on Delinquency and Its Treatment*, New Haven, Yale University Press, 1936.

⁵³ Ibid., p. 65.

It finally appears that no less than *91 per cent of the delinquents* gave clear evidence of being or having been very unhappy and discontented in their life circumstances or extremely disturbed because of emotion-provoking situations or experiences. In great contradistinction we found similar evidence of inner stresses at the most in *only 13 per cent of the controls*.⁵⁴

On the basis of this and other evidence delinquency was interpreted by the writers as being "clearly a reaction to emotional disturbances and discomforts" and therefore "especially meaningful for the individual of whose behavior it is a part."

The enumeration of the disturbances of the feeling life characterizing the delinquents . . . place squarely before us the material for an entirely new outlook on the activating forces of delinquent behavior. The frustrations of the fundamental urges, desires, and wishes which belong to the normal stream of life's activities are plainly to be seen. More explicitly, the desires for human relationships which are satisfying as they afford affectional acceptance and security, recognition of the individual as a personality, realization of social adequacy, opportunity for satisfactory accomplishment, for independence, for new experiences, and for outlets and possessions have somehow been thwarted.

The obstructions have engendered feelings of dissatisfaction, deprivation, inadequacy, jealousy, or inner conflict which themselves are the discomforts antedating the delinquent behavior.⁵⁵

Frustrated in various ways, the child may find in delinquency a means of escaping (at least temporarily) from unpleasant situations. He may attempt to achieve compensatory satisfactions through it. He may be bolstering up his ego or seeking revenge. He may be trying to gain a maximum of self-satisfaction or responding to instinctual urges or seeking punishment. These, say Healy and Bronner, are some of the meanings delinquency may have for a child. As to why he should turn to delinquency rather than to other forms of rebellion,

⁵⁴ *Ibid.*, p. 122.

⁵⁵ *Ibid.*, p. 132.

they believe the answer lies partly in the ideas and values that characterize American life.

With all the ideas of delinquency that in our modern world pour in upon the young individual from many sources, the acceptance of these ideas as offering a mode of behavior which may be pursued is dependent upon whether or not there are other sufficient satisfactions. Under the stress of emotional discomforts, even the discomforts of "nothing else to do," the invitation to dwell upon and to accept such ideas is especially great. Then certainly there is more ready acceptance of ideas of delinquency if they accord with what might be termed special needs of the individual, as in the cases of those hyper-active, over-restless boys who in their emotional life have found frustrations. Under certain circumstances it may be healthier and more normal to join in the activities and imbibe the ideas of a delinquent crowd than to be a withdrawing, soft, effeminate "mother's boy" or to mope at home and develop an abnormal phantasy life.⁵⁶

Obstacles to psychiatric work with delinquents

If such theories as to the causes of delinquency are accepted as valid, it becomes clear that attempts to prevent delinquency by means of psychiatric treatment face many obstacles. Some lie in the delinquents' personality traits. Energetic and outgoing, many of them find excitement and companionship in delinquency and a means of self-realization for which a poverty-stricken environment can offer only mediocre substitutes at best. Many such children are not apt to want the help of a psychiatrist and may not respond favorably to the efforts of social workers to find other outlets for their energies. Other delinquents are too emotionally maladjusted to respond to psychiatric treatment. Healy and Bronner found that 18 per cent of the delinquents in their study could be "definitely diagnosed as abnormal personalities of various types, brain injury cases, postencephalitics, confirmed homosexuals, psychotics or prepsychotics, as well as severe cases of neurosis and

⁵⁶ Ibid., p. 136.

'neurotic characters' who through the irrational nature of their delinquencies give evidence of suffering from severe mental conflicts."⁵⁷

Other handicaps to treatment are to be found in parents' attitudes with respect to delinquency and delinquents. In a certain proportion of cases it is the parent himself who enters the complaint against a child, while many others are openly hostile to their delinquent children.⁵⁸ Bertha Reynolds found in a small series of cases in which children had been committed to a reform school that most parents were fatalistic about their children's delinquency and had little conception that anything might be done about it, their modes of punishment having failed. They tended to put the blame on some one outstanding circumstance (such as the mother's interference or some person's ill health), were apathetic about attempting to change local conditions and institutions, and seemed to expect no more than they had received from the community. She concluded that the agency (one that offered case work as well as institutional treatment) "had tended to overestimate the extent to which the parents of children committed to [correctional institutions] would either understand what social case work could offer them or would take the initiative in using it."⁵⁹

A study of all the children living on a certain street in the tenement area of a large city revealed a close association between family relationships and children's conduct.⁶⁰ The par-

⁵⁷ *Ibid.*, p. 163.

⁵⁸ Healy and Bronner report that 46 of the 96 emotionally deprived children felt keenly that they were rejected, deprived, not understood in affectional relationships, 34 had intense feelings of discomfort about family disharmony, and 31 were bitterly jealous of their siblings because they were markedly favored. *Ibid.*, p. 128.

⁵⁹ Bertha Capen Reynolds, "Between Client and Community," *Smith College Studies in Social Work*, Vol. V (1934), p. 51. Other findings cited above are from pages 51, 57, and 60.

⁶⁰ Virginia Boggess, "Some Factors Accounting for the Variation in the Social Adjustment of Children Living in a Tenement Area," *Smith College Studies in Social Work*, Vol. VI (1936), p. 324-59.

ents of the delinquents and near-delinquents were unhappy, discouraged people much criticized by their neighbors for their shiftlessness and discordant home life. They definitely neglected their children, made little attempt to discipline them, and were more or less uninterested in what they did or what became of them. While case records show that not all parents of delinquents have such attitudes, they are sufficiently common to lead many clinicians to the conviction that it is frequently futile to work with delinquents while they are in their own homes. Healy and Bronner report that favorable results were often obtained with delinquents who were placed in good foster homes, but that "any return of a former delinquent to unchanged family relationships and to bad neighborhood conditions nearly always meant renewed delinquency."⁶¹

Then, too, children who are referred to a clinic by a court or probation officer tend to attribute to the clinic the law's punishing attitudes. A review of a series of sixty-four such cases known to the Jewish Board of Guardians of New York City showed that thirty per cent of the children or their parents so rejected treatment that nothing whatsoever could be accomplished.⁶² Doubtless a skilful interpretation and demonstration of the clinic's function can overcome some such attitudes, but it cannot be overlooked that apprehended delinquents seldom go to a clinic on their own or their parents' initiative but because some person who has the power to punish them says they must be examined.

A final set of factors that handicaps clinic work with delin-

⁶¹ Healy and Bronner, *op. cit.*, p. 212. The authors note in addition that their earlier-reported favorable results of selective foster-home placing as a cure for delinquency (*Reconstructing Behavior in Youth*, New York, Knopf, 1929) were not maintained when the children, after a period of years, returned to their former inimical home conditions. Footnote, p. 212.

⁶² Elaine Rappaport and Laura Stolzenburg, unpublished theses on file in Smith College Library. Abstracts of the theses in *Smith College Studies in Social Work*, Vol. VI (1936), pp. 282, 283.

quents is found in the social conditions under which so many delinquents live. It was the realization of the frequent hopelessness of attempting to help children to adjust to extreme economic deprivations and to a neighborhood life that offers few constructive satisfactions that early led child guidance clinics to concentrate their efforts upon other types of problem children.⁶³ Healy, reviewing the work of the clinics, said:

In recent years the definite shift away from attempting to deal extensively with the problems of delinquency is due principally to the fact that the clinic cannot have control enough over the individual or over his social situation. Aside from the individuals who become delinquent mainly because of inner conflicts and frustrations, it is plainly discernible that in the complex of factors which make for delinquency there are many social elements, deprivations and pressures that cannot possibly be bettered by clinical effort alone. The conception that the guidance clinic may be of great aid in a program for the prevention of delinquency remains thoroughly valid, but indispensable for any such program is well-conceived, cooperative, social effort. . . . Whatever is undertaken, I am convinced . . . that any project for the prevention of delinquency will be confronted with the necessity for modification of the spirit or ideology of community life. . . . As it stands at present in most large communities, it is impossible for child guidance clinics, through their work with individual cases, to be playing any very important part in the prevention of delinquent and criminal careers.⁶⁴

The statistics of results of treatment of delinquents provide considerable backing for Healy's conclusion. The largest

⁶³ A count of the patients given "full study" by the thirteen community clinics reporting to the National Committee for Mental Hygiene in 1929 showed that only fifteen per cent of them were delinquents, even when that term was enlarged to include truants from home and school and those with "habitually uncontrollable conduct" but not court cases. White House Conference on Child Health and Protection, *The Delinquent Child*, New York, Century Co., 1932, Appendix II, p. 358.

⁶⁴ William Healy, *Twenty-five Years of Child Guidance*, Studies from the Institute for Juvenile Research, Series C, Number 256, Illinois Department of Public Welfare (1934), p. 14-15.

study of recidivism among juvenile delinquents—that conducted by Sheldon and Eleanor Glueck⁶⁵—revealed that, during the five-year period following 1917 to 1922, 88 per cent of the 923 juvenile delinquents examined by the Judge Baker Foundation had continued their misconduct. Seventy per cent of these recidivists had been convicted of serious offenses and a third of them had been arrested four or more times. A similar but much smaller study of delinquents examined by the Illinois Institute for Juvenile Research gave somewhat more favorable results but still showed that a large proportion of the children (62.5 per cent) had been recidivists within a seven-year period.⁶⁶ It may be, however, that to judge a child's adjustment by the fact that at one time or another over a period of years he appeared before a court is to take too gloomy a view of the matter, especially when it is remembered that the police are prone to apprehend boys who have once been convicted. In the Institute for Juvenile Research study the children were also rated with respect to their general history of social conformity over the seven-year period. It was found that over half of the boys and a third of the girls were making a good social adjustment at the time the follow-up study was made, that the cessation of recidivism had occurred at least two years prior to the investigation in almost all these cases, and that only about a fourth of the children had been rather consistently maladjusted throughout the period. Just about a third of the boys who were recidivists according to the Glueck definition were in penal institu-

⁶⁵ Sheldon and Eleanor Glueck, *One Thousand Juvenile Delinquents: Their Treatment by Court and Clinic*, Cambridge, Harvard University Press, 1934, p. 167.

⁶⁶ Jane Adams, Marjorie Arnold, and Helen Witmer, "Recidivism among Juvenile Delinquents Examined by the Illinois Institute for Juvenile Research," *Smith College Studies in Social Work*, Vol. VI (1936), p. 304. This study covers the 119 children, 82 of them boys, who were examined at the main office of the Institute for Juvenile Research between June 1, 1927 and June 30, 1928. Their behavior for seven years was traced through records and personal interviews by two case work students.

tions or actively delinquent at the time the follow-up study was made.⁶⁷

Some requisites for effective work with delinquents

In the discussion that followed the publication of the Glueck report, much emphasis was placed upon the fact that the delinquents had been studied but not treated by the Judge Baker Foundation, that organization having done no more than make recommendations to the court concerning their care. The Institute for Juvenile Research followed a similar policy with respect to court cases. Since this method of examination and recommendations is the one most frequently used by traveling clinics, it is of interest to note what may be accomplished when clinics can themselves offer treatment to delinquents and their families. The previously described study by Healy and Bronner was conducted in three clinics on a research basis, the plan being to do work "with the delinquent himself carefully aimed at meeting the causes of his troubles, while at the same time attempting therapeutic modification of the factors in family life which had been directly or indirectly producing the delinquent's tendencies."⁶⁸ Twenty-eight of the 143 children could not be given psychiatric treatment because they or their parents rejected help or because the court immediately sentenced them to an institution. Of the remaining, seventy received "moderate" and forty-five "intensive" psychiatric treatment, and, in addition, the clinics' case workers and other social agencies gave much attention to all but five of the total group of children. Under such treatment conditions, half of the children ceased their delinquent behavior, and a similar proportion were found not to have become recidivists during the subsequent two-year period. Something over a third continued their de-

⁶⁷ *Ibid.*, p. 314-15.

⁶⁸ Healy and Bronner, *op. cit.*, p. 142.

linquencies.⁶⁹ These percentages compare rather favorably with results achieved with unselected groups of problem children treated by child guidance clinics and therefore suggest that the treatment of delinquents is no more difficult than that of the general run of child guidance patients.⁷⁰

In addition, the Healy and Bronner study offers prognostic classifications distinguishing the treatable from the non-treatable delinquents. They classified twenty-six of the 143 children as having "abnormal or markedly neurotic personalities, or suffering from severe mental conflicts or being mental defectives." Another group of fifty consisted of those cases "in which the social pathology, particularly as involving human relationships within or outside the family circle, appears to weigh so heavily against the successful treatment of the delinquent in his family environment that the given situation seems largely hopeless." The final group of sixty-seven was composed of the cases in which the "factors of personality difficulty and social pathology were not so severe or so piled up that they seemed to offer insuperable obstacles to therapy." During the two or more years in which they were followed after treatment ended, seventy-two per cent of this latter group had not again been delinquent as compared with thirty-eight per cent of the second group and nineteen per cent of the first group.⁷¹

From these theories and observations about juvenile delinquents several conclusions with respect to the feasibility of prevention of delinquency as an objective of a child psychiatry program emerge. Prevention of delinquency has at least two possible meanings. It may refer—like the prevention-of-psychosis objective—to attempts to forestall delinquency by selecting for treatment the children who are considered likely

⁶⁹ *Ibid.*, p. 171.

⁷⁰ Helen Leland Witmer, "A Comparison of Treatment Results in Various Types of Child Guidance Clinics," *op. cit.* (n. 35), p. 351-60.

⁷¹ *Ibid.*, p. 161-71.

to become delinquents. This was the point of view the demonstration child guidance clinics speedily came to when they found their prevention-of-delinquency program threatened by their inability to do much constructive work with children referred to them by the courts.⁷² This mode of work, however, runs up against many of the difficulties previously discussed in reference to identifying and treating "pre-psychotic" children. It is commonly believed, for instance, that truancy is a forerunner of delinquency. Yet Healy and Bronner found in an early study that only about a third of 4,000 delinquents had been truants;⁷³ Shaw reported that less than a third of 2,447 Chicago truants became delinquents;⁷⁴ and the New York Crime Commission concluded that the prognosis of serious crime on the basis of amount of truancy is not possible.⁷⁵ In addition, any psychiatric program that tends to label children—or gives teachers, neighbors and others an excuse for labeling children—as potential criminals is open to all the objections previously discussed. Actually, of course, the demonstration clinics and others that turned from courts to schools, social agencies, and parents as the better sources from which to draw patients more or less deliberately dropped the prevention-of-delinquency objective as their attention became focused upon the present needs of problem children instead.

But to discard the goal of prevention is not to refuse psychiatric assistance to children who have become delinquent. It was earlier stated that the role of psychiatry in work with delinquents must depend upon the extent to which delin-

⁷² George S. Stevenson and Geddes Smith, *Child Guidance Clinics: A Quarter Century of Development*, New York, The Commonwealth Fund, 1934, pp. 24, 28.

⁷³ William Healy and Augusta F. Bronner, Judge Baker Foundation Case Studies, Series 1, Case 11, Boston, 1923, p. 7a.

⁷⁴ Clifford Shaw, *Delinquency Areas*, Chicago, University of Chicago Press, 1929, p. 33.

⁷⁵ New York Crime Commission, *A Study of Truants in New York Public Schools*, 1927, p. 14.

quency is a psychological problem. Our review of theory and research leads to the conclusion that in most cases psychological and social causes are subtly intertwined. The social handicaps under which many delinquents live and to which their delinquency seems a more or less healthy response has led many clinicians to conclude that psychiatric clinics have little to offer delinquents. On the other hand, in some cases delinquency represents so severe a neurotic symptom that again—as in the case of the “pre-psychotics”—psychiatric treatment is often ineffectual.⁷⁶

The most recent studies suggest, however, that between these two types of cases are many delinquents who may be helped by a child guidance clinic if that clinic has adequate resources for treatment. Such is the optimistic conclusion that can be drawn from Healy and Bronner's latest investigation. Comparing the findings of that study with those of the Gluecks and others, one is led to the conclusion that much of the current, rather hopeless attitude with respect to the treatment of delinquents should be attributed to the lacks in the clinics and the communities rather than in the delinquents. Given a well-trained clinic staff of adequate size and enough time really to treat each child and his family who have some interest in being helped (and the Healy and Bronner study reported that almost all the delinquents were initially interested in treatment⁷⁷), it appears that even a group of delinquents specifically selected as being “potentially serious offenders”⁷⁸ are as amenable to treatment as the average run of child guidance patients.

Some of the minimum requirements for such a clinic will be discussed in subsequent chapters, but it can be noted here

⁷⁶ See Franz Alexander and William Healy, *Roots of Crime*, New York, Alfred A. Knopf, 1935.

⁷⁷ Healy and Bronner, *New Light on Delinquency and Its Treatment*, op. cit., p. 144.

⁷⁸ *Ibid.*, p. 17.

that our previous descriptions of the clinics under state auspices give little indication that many of them can offer this type of service. Such treatment, moreover, is focused upon the delinquent's own problems and not upon the recurrence of the particular symptom which is called delinquency. Prevention in the literal sense (that is, the averting of some future mode of behavior) would seem to be an even less tenable aim in treating delinquents than in treating those who are thought to be headed toward psychoses. In both cases a psychiatric program can profitably aim only at the "treatment of an existing unhappiness rather than at prevention of some impending disease"⁷⁹ or misconduct. This is the generalized conclusion to which our review of theory and practice in the field of prevention seems to lead. It has been stated by Adolf Meyer in a way that may serve as a summary to this chapter:

We are at times made to believe that all our mental hygiene work and effort aims largely at the prevention of "insanity and crime," just as the early advocates of psychopathic hospitals made it look as if, through the creation of a psychopathic hospital in each state, the existing state hospital care would then be made less expensive and perhaps in part unnecessary. To be sure, early work means a heading off of some of the disastrous depth of aberration and deviation and much unnecessary blundering. But the chief goal is much more direct; it offers prompter and more and more enlightened help both to patient and family and to the community in respect to really new problems, largely left to themselves before; it is a direct service to the positive needs and opportunities of the community in behalf of what I reemphasize as health, happiness, efficiency, and social adaptation.⁸⁰

⁷⁹ Bronson Crothers, *A Pediatrician in Search of Mental Hygiene*, New York, The Commonwealth Fund, 1937, p. 75.

⁸⁰ Adolf Meyer, "Individualism and the Organization of Neuropsychiatric Work in the Community," *Mental Hygiene*, Vol. IV (October 1925), p. 675-85.

CHAPTER ELEVEN

Psychiatric Service for the Feebleminded and Neurologically Disabled

IT was the argument of a previous chapter that some of the puzzling problems of policy and administration in state-financed psychiatric clinics for children would probably disappear if the clinics could clearly define their function. It was noted there that the present clinics have three main objectives—sometimes one, sometimes another predominating—and that these place different requirements upon the clinics in terms of services to be offered, patients to be served, and personnel and training. One of the three objectives was that discussed in the preceding chapter—the prevention of psychosis and crime. If the conclusions of that chapter are accepted (that psychiatric clinics can give help only with present difficulties and not with future contingencies), the alternatives before a clinic would seem to be considerably clarified. The clinic's function could be defined as one of serving those groups of children who are so handicapped by mental or neurological defects or diseases that they are frequently regarded as in need of institutional care. Or, alternatively, it could be held that the clinic's proper activity is one of promoting the mental health of children whose potentialities are more adequate and whose difficulties are primarily of social and emotional origin.

There are—it must be granted at the outset—disadvantages to such a dichotomy of purpose. To confine a clinic to the first group of cases, for instance, doubtless enhances the possibility of stigmatizing the children who become its patients. But what with “special classes,” on the one hand, and the usual behavior and attitudes of the unenlightened public,

on the other, it is likely that the majority of such children are already stigmatized before they come to the clinic. If the clinic can give to parents and teachers genuine help in understanding these children's potentialities and limitations, it would seem that the danger of further damaging their self-esteem is not too great. There is, however, the likelihood that to such a clinic would also be brought children whose difficulties are not due to mental defects or organic disorders. To such children, already misunderstood, examination by a clinic that specializes in work with the grossly disabled would probably be a serious threat to emotional security, one that could be offset only by unusually intelligent handling by the staff of the clinic.

More serious, perhaps, would be the disadvantage which might arise out of the specialization itself. There might be implicit in the proposed division of function the assumption that the two types of cases are mutually exclusive and that a clear-cut differentiation between organic and psychogenic origins to children's behavior problems can be made. If this were so, it would be most unfortunate. For it is a necessary axiom of all work based on dynamic psychiatry that, as Schilder says, the desires and strivings that come to the surface under any conditions are an integral part of the individual's personality, and not merely the result of a disease process.¹ Mentally and neurologically handicapped children are doubtless particularly prone to suffer from feelings of difference, since many of them are so clearly set apart from other children by their disabilities, and the behavior disorders that are apt to occasion their referral to a psychiatric clinic frequently spring from such sources. They, like other problem children (or all children, for that matter), need to find some basis for security and self-confidence, and they are unlikely to be

¹ Paul Schilder, "Personality in the Light of Psychoanalysis," *Psychoanalytic Quarterly*, Vol. XXII (1935), p. 37.

helped in this area if a clinic thinks of them only in terms of mental and physical examinations.

A basis for distinction between clinics serving the mentally or neurologically handicapped children and those chiefly concerned with children whose problems spring from other sources is to be found, however, in the kind of service a clinic can offer the latter children and their parents. It is this fact that lies back of our suggestion that clinics could probably be most effective if they would state their function in terms of serving one or the other type of cases. Aside from the tolerance, understanding, and non-judgmental attitudes that are required for psychiatric work with any people, each of these two groups of cases makes particular demands upon a clinic by reason of the specific nature of the major source of the children's difficulties. A given clinic might, of course, attempt to serve both groups, but it could do that most effectively only if it were prepared to meet the peculiar needs of each of them. We shall consider first some of the fundamental requirements for work with the children who are mentally defective or neurologically disabled, while the next chapter will be concerned with problems arising in connection with work with the other group.

The kinds of cases that would predominate in a clinic that aimed to reduce the number of commitments to institutions would be those that already form the bulk of the patients accepted for study by traveling clinics. These are the children about whom communities untutored in mental hygiene are most definitely concerned, the ones they want to "put away" because they do not know what else to do with them. They are the definitely feeble-minded, the epileptic, the post-encephalitic, those suffering from chorea, brain injuries, and other neurological difficulties. Small-town schools rarely have the special facilities for identifying and training the feeble-

mind, and physicians who are general practitioners frequently feel in need of help in diagnosing and treating the others. Our review of the traveling clinics showed that many of them were greatly appreciated by certain groups because they made recommendations about caring for such children. In electing to work in this area, then, clinics would probably find the public relatively well prepared to make use of their services.

In spite of this attitude of acceptance, however, the clinics would doubtless still find many obstacles to their work if they attempted to alter their traditional practices. A comparison of the typical recommendations that the present clinics make and the groups of people who praise their work suggests one of the reasons why the clinics are often so well received. Characteristically, these recommendations advise the school authorities how to get rid of the children! Then, too, they give the schools (and courts and social agencies as well) diagnostic labels which they may affix to the children and so relieve themselves of the need to educate them or otherwise deal with them as individuals. Again and again the statement was heard that the clinics were useful because they gave expert testimony that children whom the schools considered feeble-minded did have that disability. This served to justify schools, one gathered, in putting children in special classes or in insisting that the parents remove them from school, while child welfare agents were often sustained in their decisions to take children from home, more or less regardless of the parents' wishes. Not that this is the whole reason for the present favorable esteem in which many clinics are held by certain groups. But the fact that so small a proportion of children are brought to the clinics on the parents' own initiative cannot be overlooked, and one of the reasons for this situation must lie in what the clinics represent to the persons most vitally affected by their work.

If the clinics were really aiming to reduce institutionalization, they would have to find some means of working with parents as well as with authoritative agencies. This change of practice would require an educational and therapeutic program that might well run counter to established ways of thinking about feeble-minded and organically handicapped children and make clinical work with them a far different thing from that rather cut-and-dried system of examinations that now prevails. It would also necessitate the provision by the communities of various facilities for the care and treatment of such children which are now seldom at hand. In brief, then, a clinical program aimed at helping these types of children to adjust to life in the community would require many changes in viewpoint on the part of both clinicians and general public, and additions to the communities' professional and material equipment as well.

THE NEEDS OF THE PATIENTS

Let us consider first what kind of help children of the types under consideration in this chapter require if any considerable proportion of them are to be expected to fit into community life. Such an analysis should lead to a more specific understanding of the requirements which such an aim would impose upon a clinic and a community and so serve to clarify some of the problems of clinical policy that have previously been listed.

Since we are concerned primarily with the role which psychiatric clinics might play in helping these groups of children, it would lead too far afield to consider the total question of their training and care. Merely to mention the types of disorders and defects here grouped together is sufficient to call attention to the fact that their requirements are not identical. The group that is the largest in many clinics is composed of the feeble-minded of various grades and conditions. It must

be remembered, however, that, as one commentator says, "mental deficiency is not in any way a disease entity but is a symptom or state occurring in several different forms in many entirely different conditions. We have to consider not only degrees of deficiency, and primary and secondary classifications, but all sorts of distinct conditions with different causations, showing different qualities and temperaments and involving different handicaps and different needs."² Among neurological disorders, there are children suffering from epilepsy, chorea, chronic encephalitis, head injuries, and the like. For some of these medical care is necessary; others are in particular need of specialized education and training. Among all the groups—and probably in a larger proportion of cases of some types than of others—are children who cannot be expected to adjust to life outside an institution under any but the most favorable home circumstances. In addition, it may sometimes be that even favorable homes have other needs that are best served by placing the patients in institutions. In spite of these differences, however, there are some needs which these children have in common and concerning which a psychiatric clinic might be of assistance.

The most outstanding of these are the needs which these children share with all children—the need for some person or persons with whom they can feel emotionally secure and the need for some opportunity to exercise whatever abilities they possess. Schilder³ points out that "mental deficiency as such generally offers a minor problem as long as it is not combined with changes in the emotional sphere and in the sphere of impulses." He adds that "mental deficiency changes the aspect of behavior problems. The emotional reactions of men-

² Noel H. M. Burke, "Discussion of the Value of the Treatment of Mental Deficiency," *Proceedings of the Royal Society of Medicine*, Vol. XXVII (1924), p. 1738-39.

³ Paul Schilder, "Organic Problems in Child Guidance," *Mental Hygiene*, Vol. XV (1931), p. 485.

tally deficient children are more difficult to understand and it is more difficult to handle them." However that may be, it seems certain that the cause of whatever emotional maladjustment may exist among the feebleminded is probably to be found largely in the same lacks that create difficulties for children with greater intellectual endowment. A recent discussion of the Royal Society of Medicine concerning the psychiatric aspects of work with mental defectives elaborated and supported that point of view with much concrete evidence. Speaking before the group, Dr. C. J. C. Earl⁴ said:

Obviously, intelligence as measured by test is not the essential differentiating factor between defect and normality. What is the essential factor is the ability to adapt to society. We are back then to the question of behavior and, with it, the question of emotion, for there is no doubt that social adaptation is largely a matter of emotional or affective-instinctive factors. . . .

The environmental factors imposing psychological strain which one finds in the background of the defective seem to be much the same as those which one finds in the problem child of normal intelligence. As a class they are certainly exposed to greater strain than the average child. In addition, two factors stand out clearly. The first and most important is the added strain due to the failures arising out of lack of intelligence, particularly in school, where the dice are heavily loaded against the child of poor verbal ability—not necessarily the defective child. . . . I may point out that here is the ideal condition for the production of an acquired emotional immaturity or the exaggeration of one already existing. . . .

The other environmental factor . . . is that of bad socio-economic circumstances, or, as I prefer to call it, sheer bad luck. An amazing number of these people either are orphans or illegitimate, or have home circumstances so bad that the perfectly normal child would have difficulty in surviving. The re-

⁴ C. J. C. Earl, "Discussion on Mental Defects from the Neurological and Psychiatric Standpoints," *Proceedings of the Royal Society of Medicine*, Vol. XXVIII (1935), pp. 797, 798.

sult is that the child either is grossly neglected, or is sent at quite an early age to some sort of institution where his emotional difficulties are increased and also where their results attract notice easily. . . . And such a child, once in an institution, has very little chance of getting out, so that whether or not he was socially ineffective inherently and from birth, he will eventually have social ineffectiveness thrust upon him. . . .

If any proof is wanted of the importance of the conditioning of response, you have it in the enormous improvement which occurs in high-grade cases when they are taken out of the old-fashioned institution and placed in a small group handled on sound psychiatric lines. I am beginning to suspect that, apart from gross inherent instability, this matter of sheer ill luck is the dominant factor in most defectives whose mental age is above 9.5 years.

As to the groups of children who suffer from organic disorders, their behavior too is thought by some psychiatrists to have an emotional as well as an organic base. Schilder, in the article previously referred to, gives various examples of the ways in which any kind of disease may affect a child's emotional adjustment. Among his illustrations are the following:

Every disease in childhood also changes the whole libido situation in the family. The child gets more and more attention. The love of the parents [or, one might add, their hate or their guilt] comes to the surface in a more open way. An acute disease in this respect certainly has another psychology than a chronic disease, and the whole aspect of a child's life may be changed in this way. . . . Itching will change the attitude of a child toward its own body. The same is true about pain. The organ that suffers will attract an enormous amount of attention, not only from the child but also from the persons around him.

His general conclusion is that "every organic disease and deficiency is . . . a psychological problem of enormous importance. . . . The events of life, the psychic attitudes, the mental and emotional problems of the child take place in an organism. The motor, instinctive, and sensory constitution

will always be at the basis of the reaction. This somatic basis may be changed by disease, but behavior will finally be shaped by the problems of life, which are, after all, problems of the personality as a whole."⁵

Even in regard to a disease with so clear a neurological involvement as epidemic encephalitis lethargica, some psychiatrists who have done much work with such patients hold that the ensuing behavior manifestations may be partially a response to adverse environmental conditions or may represent the emergence of latent neurotic tendencies. As Shrubsall⁶ says, "The changes in conduct noted as sequelae to an attack of encephalitis are of very varied character, but seem to take their origin in the state of irritability, lack of inhibition, and consequent impulsiveness which immediately follows the acute phase of the illness, and becomes fixed, either by habit formation or by secondary development of psycho-neuroses, dependent on the particular features of the individual environment."⁷ Bond and Appel⁸ report that the mere removal of postencephalitic children to an institution specially set up for their care tended to relieve certain of their behavior difficulties. Regarding this experience they comment that "at first the children seemed to be watching for the inconsistencies they were used to at home, then relaxing pleasantly when they failed to find them." While most of them improved in the hospital, only about thirty-five per cent retained their good adjustment after they returned home. Shrubsall's⁹ de-

⁵ Paul Schilder, *op. cit.*, p. 485-86.

⁶ F. C. Shrubsall, "Discussion on the Mental Sequelae of Encephalitis Lethargica," *Proceedings of the Royal Society of Medicine*, Vol. XVIII (1925), p. 22.

⁷ For other suggestions that the postencephalitic condition may represent, in part at least, the coming to the surface of a latent neurotic tendency, see discussion by Worster-Drought and D. N. Hardcastle, *ibid.*, p. 32.

⁸ Earl Bond and Kenneth E. Appel, *The Treatment of Behavior Disorders Following Encephalitis*, New York, The Commonwealth Fund, 1931 (out of print), pp. 47, 51, 142.

⁹ F. C. Shrubsall, *op. cit.*, p. 22-23.

scription of the home and school conditions under which such children frequently live provides one explanation why these admittedly more easily irritated and fatigued children find life outside a specially equipped institution difficult:

Judging from the results so far to hand, irritability, impatience, excitability, and spitefulness may pass off, and control may be regained provided favorable conditions are attainable, but often the home environment is such as adds to the difficulty. When the child's condition is such as to lead to his being kept in the foreground or alternately petted and baited, many secondary manifestations follow. . . . There is no doubt that such more or less intentional baiting does occur from time to time at school, despite the best efforts of the teacher, so that it is little surprise that a boy with slight paresis of a limb develops a marked paralysis whenever the question of return to school is raised. . . . In some cases, too, the conduct observed, although said to be foreign to the previous record of the sufferer, is such as might have been expected to occur from the admitted traits of other members of the family, the illness having perhaps precipitated the onset of a feature that would in any case have arisen in due course. Thus the mother of one girl who was out of control, although previously she had been placid, explained excitedly that "her (the girl's) father would as soon knife you as look at you." . . . Also, in some of the cases of persistent theft, there had been examples in which other members of the family have shown similar conduct without having so ready an excuse.

Mere removal from home is not sufficient, however, to cure these children. Healy¹⁰ has reported that, in spite of long and careful experiments in foster home care, he had "yet to see a severe case successfully handled by placing," and Bond and Appel conclude that a hospital unit especially designed for this type of patient is necessary for their care.¹¹ In such an institution one of the main features must be its facilities for psychiatric treatment.

¹⁰ William Healy, *Reconstructing Behavior in Youth*, New York, Alfred A. Knopf, 1929, p. 69.

¹¹ Bond and Appel, *op. cit.*, p. 145.

Among the things that facilitate contact with children, the most important perhaps is knowledge of their inner experiences. The mask of conventional responses must be removed if the driving forces of the individual are to be understood.¹²

Since such institutions are rare—if they exist at all—it may be that psychiatric clinics are the next best substitute for them.

ESSENTIALS OF EFFECTIVE WORK

It is obvious, however, that if a clinic is to serve feeble-minded children and those who suffer from neurological disturbances it must provide services that are very different from those customarily offered by state hospitals and departments of mental hygiene. Clinics that confine their work largely to diagnosis and rather stereotyped recommendations with respect to school changes or placement may be implicitly recognizing some of these needs of their patients, in that they are suggesting that the children's living and working conditions be changed; but it is doubtful that their understanding of the source of the difficulties carries over to the school and social welfare authorities when emphasis is put upon diagnosis. For to the typical layman a diagnosis closes a case. Feeble-mindedness implies that a child is not able to learn; postencephalitis means that his behavior is uncontrollable. It is the function of the psychiatric clinic to convey to the persons concerned, by one means or another, the fact that a child and his behavior are not explained by one set of data alone. The diseases and defects from which these children suffer set limits to their potentialities for achievement and, in some cases, even for social adjustment, but they do not explain all of their behavior nor, in most cases, give indication that nothing can be done to help them.

The questions before a psychiatric clinic, then, center

¹² *Ibid.*, p. 54.

around the chief causes of the behavior that occasions the referral to the clinic and the areas in which help must be offered if the child is to utilize his latent capacities. To state the problems in this manner is not to imply that the clinics can be of help to all children or that the responsibility for helping them rests wholly upon the clinics. But the provision of services does carry with it the responsibility of attempting to assess the potentialities and limitations in each particular case, in spite of the recognition that a treatment program in psychiatry is a mutual undertaking between community, clinic, and the individuals concerned.

One of the most important—and neglected—areas in work with mentally defective and neurologically disabled children is that of their families' attitudes and feelings concerning them. It is frequently found that parents are more than usually attached to their handicapped children. On the genesis of such attitudes psychiatry has thrown much light and revealed that protective behavior may follow from guilt and hostility as well as from affection and concern. Then, too, social values and fears also play a part. There are forms of behavior that must be concealed from public knowledge if possible, not only for the child's sake but because of pity to be endured otherwise and suspicions of tainted heredity. Nor are people outside the family the only ones to harbor such suspicions. So widespread is the current belief in the heredity of nervous and mental diseases and defects that few families can escape worry and perhaps mutual accusations when they have a child that has any disability that affects his mental functioning. While some of them react to this situation by overprotecting the children, others become intolerant of them instead and desire nothing more than that they be removed from their sight. Still others display both of these reactions in direct or subtle ways, while some are able more effectively

to balance pleasure and pain and make decisions that leave them more free emotionally.

Whatever the form which the parents' feelings about these handicapped children takes, it is one of the most important elements in the psychiatric clinic's work with the case. Far too frequently clinics have been concerned only with what the schools, courts, or other agencies see as the problems, and plans for treatment have seldom taken the families' desires into account. Time and again one hears of school and court and social agency workers using a clinic's diagnosis of, say, feeble-mindedness as a club to force parents to do what these workers think is best for the children. Nor are the clinics themselves usually helpful even when they do recognize that home conditions are accentuating a child's difficulty. The case records contain frequent notations that parents' attitudes must be changed, but the local workers with whom the clinics' recommendations are left were found by our investigators to be baffled by the difficulties they encountered in this area. Modern case work suggests that little that is constructive can be accomplished as long as the approach is from so negative an angle. Somehow or other a clinic that would serve the psychiatric needs of any group of children must find a method of working with and through the parents and using their desires as the basis for mutual planning in regard to the children's care and treatment. This is particularly necessary in work with the mentally and neurologically handicapped, for with such children direct psychiatric help is less feasible, nor are they apt to be as capable as other children of finding outside compensations for adverse home conditions.

Another group of persons whose feelings and desires are apt to be overlooked are the patients themselves. In the rapid-fire work of most traveling clinics too much emphasis is apt to be put upon tests—psychological and physical—and too

little (especially when the tests reveal one obvious reason for the disorder) upon the patient's subjective responses. In fact it is the practice of many clinics to dispense with the psychiatric examination entirely when psychometric ratings or physical examinations provide a diagnosis. It is probably true that the formal psychiatric interview contributes little to the clinic's understanding of these children, but such an observation suggests only the need for change in the psychiatrist's approach. If it is granted that work with even the very feeble-minded children must be individualized on the basis of their needs and desires, it is the psychiatrist's peculiar contribution to the treatment plan to show the psychological motivation of a patient's behavior. If this is necessary for work with the feeble-minded, it is even more necessary for work with the children who are neurologically disabled. A considerable proportion of them have adequate intellectual abilities and so are even more likely to suffer from the realization that they are different from other children. To help them to accept the limitations and the frustrations imposed by their physical disease is perhaps an impossible goal for even the most skilled psychiatrist; but it would seem to lie within the province of psychiatry to discover the particular sources of the children's discomforts, on the basis of which plans could be made for removing or alleviating them or helping the children find some socially acceptable compensatory activities.

In brief, then, the peculiar contribution of a psychiatric clinic—as distinguished from a psychological or a medical one—should be its ability to understand and portray the emotional needs of the children whom it examines, and the attitudes and desires of their parents concerning them. To this unique ability a clinic conducted on a “threefold” basis adds its facilities for testing the children's intellectual and occupational capacities, for diagnosing the physical basis of their disorders, and for studying the social environment in which

they live. Out of these data a picture of the child's assets and liabilities can be drawn up which can be of help to those planning to carry on further work with him. But these data are useless—or even harmful—if they are not set against the background of the child's feelings and his parents' desires. Even then the work of the clinic may be wasted if the persons to whom the interpretation of the case is given have no appreciation of what can be most summarily described as the mental hygiene point of view. In most communities served by traveling clinics there will be, therefore, need for educational work as well as for examination and treatment of individual cases. And the central objective of such work—like that of the study of the individual case—is to portray the child as a human being and not as an object to be accounted for by a diagnostic label.

Such a description of the work of psychiatric clinics with respect to children who are feebleminded or neurologically disabled does not, however, serve to differentiate them from clinics serving other types of children. The possibility of that distinction rests upon other considerations growing out of the needs that are specific to those groups of children. These can be stated both positively and negatively. On the latter side, it is widely held by psychiatrists that few such children are good subjects for psychiatric treatment. In addition, it may well be that a considerable proportion of them have parents who can accept advice in regard to their care; that is—to state the same matter in another way—that the proportion of children whose difficulties are due to adverse parental attitudes may be smaller than among typical child guidance cases. On the positive side, these children are in need of various forms of therapy and training that must be provided by some person other than a psychiatrist—medical supervision, various forms of specialized education, recreation adapted to their capacities, and the like.

For the most part, the treatment such children would therefore require could not be given by a clinic. With regard to physical problems, the psychiatrist could offer consultation with private physicians; on educational problems the psychologist could confer with the schools. Work with the parents would probably be of chief importance, for most of the responsibility for the care and training of the children would rest with them. Perhaps special facilities for training would be required, but here again the work would not be that for which a psychiatric clinic is equipped. The clinic could advise in regard to the children's emotional needs, but the more technical aspects of their training would have to be left to specialized services. Much of the value of the clinic, then, would lie in its advisory work with other social agencies, schools, and courts, not only in regard to individual children but in introducing for their consideration the general point of view of mental hygiene. Through such services the clinic would be able to help the community plan for the care and training of the children suffering from intellectual limitations and neurological difficulties. In the course of examining such children some would come to its attention whose behavior was attributable to more purely emotional causes. To them the clinic, in order to fulfill its function, would have to be able to offer psychiatric treatment or, at least, to exert its influence to have such service provided by some other agency in the community.

TRAINING AND SERVICES OF STAFF MEMBERS

What kind of staff would be needed to give such services? It would seem necessary that it contain psychiatrists, psychologists, and social workers, since physical and psychiatric and psychological examinations would be needed for understanding the nature of the children's problems and their potentialities, and an evaluation of the social resources and the

parents' attitudes would be required as a basis for planning for their education. The more important question, however, is what sort of training these staff members should have, and what should be the division of duties among them. It is impossible, of course, to set up exact criteria. The point to be made here is that one important criterion for judging the professional preparation required for the work is provided by the list of services a clinic with this particular conception of its objective would render.

It has been suggested that the psychiatrist's chief task in such a clinic is to diagnose physical problems and to judge the extent to which they have been accentuated or caused by emotional maladjustments. It would seem necessary, therefore, that his neurological and psychiatric training be supplemented by some experience in institutions for, say, the epileptic and the feebleminded, and some opportunity for observation, at least, of the more difficult cases that come before a child guidance clinic. The practical question for most state hospitals is whether "ward psychiatrists" are equipped for this type of work with children. It is recognized that training in the diagnosis and treatment of adult psychotic patients gives little basis for understanding the complex of situations and attitudes that produces problems in children, but it is sometimes held that this limitation does not apply to psychiatrists who deal only with the feebleminded and neurological patients. Some of the reasons for holding that even these psychiatrists need special training in child psychiatry have already been considered. On the one hand, it is not always possible to make a clear distinction between neurological and psychiatric cases. Postencephalitis, for instance, is a frequent diagnosis in clinics that emphasize organic causes, while it appears rarely in the statistics of clinics that have been influenced by child guidance theory. Then, too, constant occupation with the diagnosis of psychotic adults predisposes a psy-

chiatrist to interpret the symptoms of children in similar terms.

On the other hand, as has already been discussed, no child suffers from his intellectual or physical limitations alone. The behavior problems that usually occasion his referral to a clinic represent his ways of reacting to external situations as well as to internal handicaps. That the former may grow out of the fact that he is different from other children is granted (children may ridicule him, parents may overprotect or abuse him, teachers may put pressures on him that are beyond his ability to accede to), but his feeling about these situations, his rationalizations, and his desires are facts that cannot be overlooked by those who would help him or his family to a better adjustment. The psychiatrist, therefore, must have more than neurological training to deal even with neurological cases if his function in a clinic is to go beyond that of physical diagnosis.

The question of the psychologist's training and his role in the clinic presents fewer difficulties in administration because there is less disagreement among authorities as to what is the function of a psychologist in such a clinic. His work would be of particular importance in a clinic of this type, for on him would rest much of the evaluation of the children's specific capacities for training. To give tests to children probably handicapped emotionally as well as intellectually requires technical training and experience; hence the testing cannot be left to a social worker or a secretary equipped only with printed instructions or a summer school course in psychology. Then, too, the psychologist frequently has the responsibility of interpreting the test findings to the persons who have requested the examination. Whether this should be included in his duties is a moot question. Some clinics leave all interpretation to the psychiatrist, who utilizes the data collected by the others of the staff to draw up an evaluation of the patient's potentialities and limitations and a plan for treatment. Others

entrust the conveying of the clinic's interpretation of the case to the social worker on the theory that this is a case work type of service that must take into consideration the attitudes and knowledge of the person receiving the information and help him work out a way of making use of it that will hopefully be beneficial to the patient. Regardless of who performs this part of the clinic's function, however, it is clear that he must have an understanding of human motivations and attitudes that is rather different from that needed for the testing of the patients themselves.

Even if the division of duties assigns to the case worker much of the work with persons outside the clinic, there is still another reason why the psychologist—in this type of clinic particularly—will need the type of training that includes a knowledge of human relationships. Most communities in rural areas are not able to provide the diversified agencies and means of education that children handicapped mentally or neurologically usually need. In such a situation it would seem necessary to extend the work of the clinic's psychologist beyond that of giving tests and include in it advising local workers, teachers, and parents in regard to the specific means and ways of training these children. In such a situation the psychologist could not confine his work wholly to the giving of information. In his attitude as well as in his discussion of the child and his needs he would necessarily convey a point of view about the psychiatric aspects of the case and would have to anticipate and understand the attitudes and reactions of the persons with whom he worked. In short, the psychologist would have need of the same appreciation of the dynamic influence of emotional factors that is required of the clinic's psychiatrist and case workers.

The case worker in a clinic of this type would have a particularly important role, since so much of both diagnosis and treatment would depend on her. The problems before the

clinic are to understand the nature of the children's difficulties, to estimate their capacity for emotional and mental development, and to assess the constructive elements in their home and community life. To the solution of the problems the psychiatrist contributes his physical and psychiatric examinations and the psychologist his various testing and training methods. The case worker has the task, either through direct interviews with parents and friends or through the medium of the referring social agency, of evaluating the home situation and learning the parents' attitudes and desires. The data gathered by all three are needed in formulating a plan for the child, but the case worker has the chief responsibility for seeing whether and how the plan can be carried out. Just how she will perform this function will necessarily vary from place to place, depending on the facilities of the community and the clinic's time schedule. It seems, however, that there are certain minima in her equipment and working methods that must be met if she is to do her work effectively.

Most important is the case worker's ability to understand the feelings and motives of parents and be able to help them to express their attitudes toward and desires in regard to the children who are the clinic's patients. For this she would have to have skill in what has been called "short-contact interviewing,"¹³ for the schedules of most traveling clinics preclude extensive case work. Her work in this area might be facilitated by the fact that with the types of patients under consideration adverse parental attitudes are perhaps somewhat less prevalent as the major causes of the children's difficulties. If this were so, it would mean that many parents would find it relatively easy to express their real feelings about the patients, and the case worker's task of helping them

¹³ For illustrations of how this method is used in actual cases, see Bertha Capen Reynolds, "An Experiment in Short-Contact Interviewing," *Smith College Studies in Social Work*, Vol. III (1932), p. 3-107.

formulate what they wanted to do about them would be less difficult and less time consuming than in typical child guidance cases. The probability of parents' attitudes being emotionally free must not be exaggerated, however. Even though many of them may be well-adjusted people, there is much in the predominating culture that makes the acceptance of severe intellectual and physical handicaps in one's children unusually difficult. Very few people can be expected to view mental defect or neurological disorders with equanimity, if only because the children so afflicted have so much to endure from their associates and adults. The effect of their presence on other children in a family is also frequently disastrous. In addition, the children who in spite of these handicaps do not manifest various forms of socially acceptable behavior (the "good-natured" feebleminded, for instance) are unlikely to come to the attention of a clinic. It is to be expected, therefore, that in most cases the social worker will find that the parents do have mixed feelings about the children who are the clinic's patients and that they will need help in planning what they wish to do about them.

In this area the case worker's task is frequently complicated by the fact that the parents often come to the clinic—if at all—only under pressure from outside sources. Schools are particularly prone to recommend and even to insist upon the examination of the children they suspect of having mental defects or disorders. If the request for examination by the clinic comes from the court the parents are even less able to refuse. In so complicated a situation—in which the authority of the state is pitted against the wishes of individuals—it is impossible to be dogmatic about the proper role of a clinic and its case worker. But it is certain that if the clinic's objective is to keep out of institutions the children who can possibly be helped to adapt to normal social life it will be necessary for the clinic to work with and not against the parents. Since

it is on the case worker that the burden of such work primarily falls, and since such work requires the greatest knowledge about human relationships, the case worker will have to be particularly well trained in this area.

In addition to her ability to work with parents, the case worker in this type of clinic needs an extensive and accurate knowledge of the resources of the communities—resources in the sense of personalities as well as technical equipment. This would include knowledge of employment possibilities, boarding and work homes, school facilities, opportunities for recreation and special training, as well as the usual social agency resources. The task of the case worker, in the period preceding the patient's examination by the psychiatrist and psychologist, is thus to prepare for the clinic a picture of the patient's home situation, of the parents' wishes with respect to his treatment, and the community's facilities for his care and training. Such a conception of the case worker's role in the clinic would require for her a kind of training that puts less emphasis on "intensive case work" and more on resources and agency relationships and yet retains that "psychiatric point of view" that enables her to be alert to the implications of words and actions.

The work of the case worker subsequent to the patient's examination will vary depending upon the clinic's service policy. As most clinics are now operated, their work ends with the diagnosis and recommendations, these usually being given to the persons (generally schools or social agencies) who first requested the study. Our survey of the clinics raised doubts as to whether in most cases this is a really satisfactory policy, even with the group of cases we are here considering. So many case records reveal such gross misunderstanding of clinics' recommendations on the part of those with whom they are left, so much misuse of diagnoses to the patients' obvious harm, that one wonders whether a clinic can ever feel that it

has performed its function adequately if it does not have some provision for at least working with the local agencies until they can more effectively utilize the kind of help clinics even now offer.

In discussing the function of the psychologist it was tacitly assumed that he would, in certain cases at least, continue his work after the time of the patient's initial examination. This work was seen largely in terms of training and perhaps supervising local people in the education of the feebleminded and organically handicapped. How much of such supervision would be necessary would depend, of course, upon what facilities were already available in the community. A clinic might well refuse to render such assistance in the larger towns, or might give it only for a demonstration period, pending the assumption of such work locally. If, however, the clinics are held in communities so small that it is unlikely that specialized services can be financed locally, recommendations for this type of care are obviously futile unless through the clinic or other county or state sources some assistance is provided for carrying them out.

With the kind of help represented by the social worker, the situation is much the same. Our survey revealed two extremes in local opinion with respect to the social service aspects of the clinics' recommendations. School nurses and county welfare agents were inclined to view the recommendations favorably but to find that they did not have the necessary time or skill to carry out the plans that called for modifying parents' attitudes. Occasionally, one of these local workers who was unusually gifted and energetic was reported to have much success with this aspect of the work, but generally it was found that this part of the recommendations was ignored or, at most, given only superficial attention. At the other extreme, local psychiatric social workers—if there were any such in the communities in which the clinics were held—

were inclined to view the clinics' work with disfavor, their usual opinion being that except for physical diagnoses and psychometric ratings the clinics' reports contributed little to their previous knowledge of the children. Reorganization of the clinics' personnel and services along the lines suggested above would probably remove this latter type of objection and provide a basis for joint local and clinical work that would promote the clinics' objectives. The former situation, however, is the more usual one, and its handicaps would become the more outstanding the more clearly the clinics saw the need for making case work with parents the center of their therapeutic program.

It is impossible to be specific as to how the necessary case work facilities could be provided locally, since conditions vary so much from place to place. Perhaps the most important point to emphasize here is the necessity for some continuing kind of case work service beyond that represented by the collection of data with respect to the parents' attitudes and desires. The interpretation of the clinic's findings about the patient and the planning for his training and care both demand understanding and skilled work with parents, since the problem is essentially theirs. If they do not want the clinic's assistance, the school may still want to proceed with a special training program, or it and other agencies may press for the child's removal from school or home. The clinic cannot assume complete responsibility for the case. But a clear-cut conception of its function will show the areas in which it is prepared to offer help; and one of the most important is that of giving parents assistance in planning for their children's welfare. To carry out this part of their work the clinics may have to employ a larger group of case workers for direct work with families than is now customary, or they may have to offer more supervisory or consultative services to local agencies. It seems unlikely that this phase of the work can be entirely assumed by

local groups, such as school nurses, who are already fully occupied with their own professional duties. But even that conclusion cannot be stated dogmatically. What is essential is that it be recognized that parents of feebleminded and neurologically disabled children are like parents of other children in having feelings about them and desires for them that cannot be ignored just because a physical basis for the children's disorder is discovered.

Such an analysis of the scope and methods of work of a clinic aiming to reduce the number of children committed to institutions may raise doubts as to why this type of clinic should be functionally distinguished from one that would serve in the general mental health field. Perhaps the distinction is not always necessary but there are some considerations that appear to be arguments in its favor. One of these concerns personnel and services. It has been suggested that in a clinic of the type here under consideration the bulk of the work could be assigned to the psychiatric social worker, since the psychiatrist's service in such cases is chiefly a diagnostic one. Although his training must equip him to understand these children who often are emotionally as well as physically handicapped, it is only rarely that he will find it feasible to carry on direct psychiatric treatment with them. On the other hand, he will probably be called upon to do more medical work than is usually required of the child guidance psychiatrist, or at least to consult more frequently with local physicians about neurological questions. The psychologist's function, too, is different from that in the usual child guidance clinic, being enlarged to include training and supervision of local persons for educational work with these particular types of cases. Since, however, so much of this part of his work is educational, it may diminish with the years, as local personnel become trained or communities provide their own resources for this work. The social worker, however, must continue on

a case-by-case basis. Even if well-trained case workers are available in the community, they cannot wholly substitute for the clinic worker if the principle of specialization in social agency function is accepted.

These forms of service put requirements upon the staff of a clinic that differ from those customarily expected of workers in the field of child guidance, although there is, of course, a basic training common to both groups. The psychiatrist in the type of clinic here under consideration probably has less need for therapeutic techniques and more need for knowledge of neurology. It would seem likely that the state hospital psychiatrist could be equipped more readily for work in this type of clinic than for child guidance. The psychologist needs a broad and specialized training both in his own technical field and in that of personal relationships. The case worker, too, has to be specially prepared for work of this kind. She needs more medical knowledge than is usually required. She must be much more of a "community worker" than is the typical psychiatric social worker. She must be prepared to give parents practical help in training their handicapped children as well as counseling with them in regard to less tangible problems. In a word, hers is a specialized job that is not adequately prepared for by training in therapeutic case work alone.

PROBABLE EFFECTIVENESS OF CLINICS FOR THE FEEBLEMINDED

When it is urged that clinics offering this type of psychiatric service be set up, it may justifiably be asked what evidence there is that their work may reduce the number of children who need to be committed to institutions. Only an inadequate answer to that question can be pieced together from the few follow-up studies of clinic patients that are available. The

answer obviously would vary with the type of patient under consideration. It has been noted above, for instance, that the treatment of postencephalitic children has not been very successful either in or out of institutions, but it is generally acknowledged that this is probably the most difficult group of patients to treat.¹⁴

The largest group of patients to be brought to clinics of the type proposed in this chapter would undoubtedly be the feebleminded without neurological disorders. It is widely recognized by workers in this field, however, that that category embraces a wide range of personalities and conditions. The conclusions of a mental hygiene survey of the feebleminded children of Cincinnati would doubtless find wide acceptance among persons who know this kind of patient well:

We have been impressed with the fact that the same elements that go to make for failure or success of mental defectives in life are in no sense different from the elements that affect the lives of normal persons. Those same elements of character and personality make-up, those same conditions in the home, and those same factors in training that speak for the successful career

¹⁴ A psychiatric social worker studying the homes of a group of postencephalitic patients treated by the Illinois Institute for Juvenile Research between 1921 and 1929 reported as follows regarding the home situations of the patients. "Twenty-seven of the 35 came from homes in which the attitudes of the parents and other siblings were unfavorable to recovery. Some of the parents were at times over-protective while at other times they complained of the patients' behavior. In other cases the parents considered the patients 'sub-normal,' criticized their drooling, their table manners, and their impulsive behavior. Others clearly showed that they no longer wished the children in the home. The other siblings were ashamed of the patients and would not allow them to accompany them on recreation trips. In only one case were the family attitudes found to be really helpful. This is the case which is believed to have made the best adjustment." Again she says, "One of the most outstanding handicaps of the post-encephalitic child is the failure of those about him to realize that he is ill and to attribute all his behavior to 'meanness.'" Two cases "showed definite improvement as soon as the families became less emotional and more objective." Her findings in regard to the adjustment of the total group were: definitely maladjusted, 23; partial improvement, 10; fairly good adjustment, 2. Lulu M. Scott, "Role of the Psychiatric Social Worker in the Treatment of Post-Encephalitis," *Smith College Studies in Social Work*, Vol. I (1930), p. 180-207.

of a normal child bear with equal force on the career of the feeble-minded child.¹⁵

It is to be expected, therefore, that the results achieved by work with such patients will vary widely, depending upon the environmental conditions under which they live and the severity of the emotional disturbance that occasions their referral to the clinic. Since the former may be expected to be somewhat more handicapping than the conditions that surround many problem children of normal intelligence, and the feeble-minded children may have less capacity for adjustment independent of external support, it may be that the results to be expected from the treatment of severely maladjusted feeble-minded children will be less favorable than in a similar group of less handicapped children. The few studies available lend support to such a conclusion.

A review of the available evidence may perhaps more profitably start, however, with the question of what kind of distribution of adjustment is to be expected of feeble-minded children in general. A report from the United States Children's Bureau, covering 1,000 "graduates" of special classes, states that several years after leaving school seventy-eight per cent of the boys and eighty per cent of the girls had a satisfactory work adjustment.¹⁶ More specific and striking evidence of the ability of the feeble-minded to become adequate citizens is offered by a follow-up study made seventeen years after Meyer and Campbell's Locust Point survey.¹⁷ In 1914 this first of a long series of mental hygiene surveys was made in a stable, working-class section of Baltimore. It covered 1,281 children—all the pupils of one public school,

¹⁵ V. V. Anderson, *Report of the Mental Hygiene Survey of Cincinnati*, National Committee for Mental Hygiene, May 1922, p. 126.

¹⁶ Fourteenth Annual Report of the Chief of the Children's Bureau, 1926, p. 12-14.

¹⁷ Ruth E. Fairbank, "The Subnormal Child—Seventeen Years After," *Mental Hygiene*, Vol. XVII (1933), p. 177-208.

three parochial schools, and two kindergartens. One hundred and sixty-six children were found to be "sufficiently subnormal to indicate a need of special training." Twenty-two of them were estimated to have no prospect of becoming self-supporting and to be "liable to recruit the ranks of the vagrants, the alcoholics, the prostitutes, and the delinquents." In addition to being very defective mentally, many of them had physical handicaps, were unable to read, write, or do errands, or were delinquent. Of seventy-eight others it was predicted that "they would be drifting along at the lowest social level." The final sixty-six were seen to have greater possibilities of economic efficiency but also greater potentialities for being detrimental to society.

Seventeen years later an attempt was made to locate these people and to assess their social adjustment. One hundred and twenty-two were located—seventy-two men and fifty women. Two thirds of the men and ninety-six per cent of the women were married. They had 173 children. Eighty per cent of the men were self-supporting even in this year of economic depression. Seventy-five per cent of the total group had never been known to a social agency. Only five women had been or were prostitutes; only five men had never had a steady job. Over forty per cent owned their own homes or were saving money. Only twenty-six per cent had ever had a delinquency record, only eleven per cent had been repeated offenders, and none had been accused of a serious crime. Even among the group of twenty-two for whom the direst predictions had been made, twelve of the seventeen who were located were found to be self-supporting. As to their children, it was discovered that only three of the 173 had an I.Q. under sixty-six and only fourteen per cent were retarded, while four children were of superior intelligence, with a mean I.Q. of 118. Compared with a control group of normal individuals also examined in the 1914 survey, the feeble-minded

group were something less than average, in that the control group tended to have better jobs and better living conditions and even fewer of them had police records but, on the other hand, not one person in the control group had a child of superior intelligence! It would seem, therefore, that in the long run feeble-minded children have almost as much chance of becoming well adjusted as have others of adequate intellectual endowment. Considering their economic handicaps, one would almost be inclined to say that their potentialities for adjustment are above average. Davies¹⁸ conclusion from a large series of studies, therefore, seems amply justified:

Studies of the after-school careers of the mentally deficient indicate definitely that the large majority of special class graduates are able to take their places in community life as ordinary, decent, working citizens, who mind their own business and make their way in such a manner as to be in no sense social burdens or menaces. Many of these graduates may be regarded as social and industrial assets. In other words, though deficient according to the usual grading of intelligence, they cannot properly be called feeble-minded.

So much, then, to demonstrate the point that the mentally defective are no more prone to social or emotional maladjustment than the rest of the population. What, however, can be expected from offering clinic services to those who as children are considered out of line? As with children of normal intelligence, the answer varies with the seriousness of the disorder. Two follow-up studies of children of low intelligence who were sufficiently maladjusted to be considered either candidates for institutions or in need of clinic examination show that from fifty to sixty per cent of them were adjusting very well some years later.¹⁹ The treatment they had

¹⁸ Stanley P. Davies, *Social Control of the Mentally Deficient*, New York, Thomas Y. Crowell Co., 1930, p. 323.

¹⁹ Louis A. Lurie, Leah Schlan, and Margaret Freiberg, "A Critical Analysis of the Progress of Fifty-Five Feeble-minded Children over a Period of

been given was apparently much like that which has been proposed in this chapter. This proportion of good adjustment is practically identical with that reported by Blackey²⁰ for a group of special class graduates a few years after leaving school. All three research studies report a close relationship between favorable personality traits, stable, pleasant home conditions, and successful adjustment. It would appear, therefore, that given these factors mentally deficient children can profit from help by a psychiatric clinic even though they may be temporarily displaying adverse behavior symptoms.

The situation is apparently quite different when the children are more seriously maladjusted. Studies from two child guidance clinics²¹ and from the Phipps Psychiatric Clinic²² report only about seventeen per cent successfully adjusted and about sixty per cent definitely maladjusted or in institu-

Eight Years," *American Journal of Orthopsychiatry*, Vol. II (1932), p. 58-69. Myra Shimberg and Wally Reichenberg, "The Success and Failure of Subnormal Problem Children in the Community," *Mental Hygiene*, Vol. XVII (1933), p. 451-65.

The first of these studies deals with 55 out of 72 Jewish children whom a survey of the public schools of Cincinnati found eligible for commitment to an institution in 1920. All the families were offered study and treatment by a neuropsychiatric clinic, to which the 55 responded. Social and vocational guidance and occupational and medical therapy were given. The cases were followed over an eight-year period. I.Q.'s ranged from 25 to 80; only four children were committed to institutions.

The other study is from the Judge Baker Foundation, Boston. The 189 children with an I.Q. under 75, studied at the clinic at least four years before 1931, who were at least 18 on that date, and who were not committed to an institution immediately after the clinical examination formed the study group. The clinic examined the children and gave recommendations to various persons regarding their care and training. That many of them were not seriously emotionally maladjusted is testified to by the fact that a large number were described as having "good personality traits."

²⁰ Eileen Blackey, "The Social and Economic Adjustment of a Group of 'Special Class' Graduates," *Smith College Studies in Social Work*, Vol. I (1930), p. 160-79.

²¹ Ida Olin, "A Follow-up Study of Twenty-Six Dull-Normal Problem Children"; Louise Hay and Beatrice Kappenburg, "The Social Adjustment of Children of Low Intelligence," *Smith College Studies in Social Work*, Vol. I (1930), p. 107-60 and Vol. II (1931), p. 146-74. These studies are from the Child Guidance Clinics of Minneapolis and St. Paul. The 33 children (I.Q.'s under 80) were patients there between 1925 and 1929. The follow-up studies were made in 1930 and 1931 by students in psychiatric social work. It is pos-

tions. These were "problem" children, most of whom lived under unfavorable home conditions. In the first group some attempt at treatment was made; in the latter only an examination was given. Success in adjustment was found by the first two studies to be associated with improvement in health, with favorable changes in parental attitudes and home relationships, and with the children being kept in the regular school classes rather than being put in special rooms. Nevertheless, the proportion of failure was unusually high, as compared with other child guidance results,²³ a finding which seemed to justify our previous conclusion that even the best of child guidance therapy cannot rectify severe maladjustment accompanied by adverse emotional conditions in the home environment.²⁴

The important question before a clinic, then, when planning for the treatment of feeble-minded problem children is what constructive factors are present in the child and in his home situation. From the point of view of treatment this

sible that the standards of adjustment used by them were somewhat higher than in the studies that put emphasis on economic adjustment. Also, these children were still in school at the time of the follow-up investigation.

²² Elaine Kinder and Elizabeth Rutherford, "Social Adjustment of Retarded Children," *Mental Hygiene*, Vol. XI (1927), p. 811-33. Twenty-five of the 68 children in this study had an I.Q. between 50 and 76. They were examined at the clinic, not institutionalized, but not given any special training. They were seven to twenty years old when followed five years after examination. It is not explicitly stated what the nature of their problems was, but one gathers that only seriously maladjusted children were accepted for examination at the clinic.

²³ Helen Leland Witmer, "A Comparison of Treatment Results in Various Types of Child Guidance Clinics," *op. cit.* (Ch. X, n. 35), p. 354. The study shows that the usual proportion of failure of child guidance treatment is about 25 per cent.

²⁴ In this connection the findings of a recent follow-up study of a group of 20 delinquent boys of borderline intelligence are of interest. These boys were studied and trained in the Oaks School, St. Charles, Illinois, an institution specifically equipped for work with defective delinquents. Five to seven years after their release half of the boys were adjusting well in the community. Frances Sisesky, "The Later Social Adjustment of a Group of Borderline Defective Delinquents Trained at the Oaks School," *Smith College Studies in Social Work*, Vol. X (1939), p. 36-49.

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means: can the parents and the patient utilize the clinic's help? It would appear from our review of the evidence that many of them probably would be able to make use of psychiatric assistance that was specially oriented toward their needs and that many children could be helped to adjust to life outside an institution.

CHAPTER TWELVE

Modern Child Guidance as a Means of Promoting Mental Health

THE requirements of a psychiatric program that aims at reducing the number of institutional admissions having been considered, the alternative objective of clinical child psychiatry remains to be discussed. This aim has been stated as offering help to children who are handicapped chiefly by emotional difficulties. Experience has shown that such difficulties are not confined to children who are delinquent, unmanageable, "queer," or addicted to "bad habits." There are many children whose maladjustment is not so obvious but who nevertheless are kept from the full utilization of their capacities by doubts and conflicts and unnecessary fears. In fact, it is held by many that the chief service of psychiatry lies with such children, for many of the more severely maladjusted are reacting to external situations and inner stresses against which psychiatry has little to offer. Not that clinicians would confine their attention to the milder cases. It is only that they recognize that a mental health program like a public health one should not be restricted to the most handicapped but should be available to all who need and want its services.

If the function of a psychiatric service for children is stated in such terms, a number of theoretical and practical questions follow, for the fulfillment of such an aim requires much more than a well-meaning desire. First, there must be considered in more detail than in previous chapters the psychiatric theory upon which such therapeutic work with children rests. The thirty and more years that have elapsed since Meyer and Freud first articulated the basic philosophy of child psychiatry have seen many refinements of theory and practice, some

of which must be summarized before the minimum requirements of a mental health program become really meaningful. Then the peculiar characteristics of child guidance must be described, for we believe that it is through this form of child psychiatry that the mental health of children in non-urban areas can best be forwarded. Next, certain important distinctions within the child guidance field with respect to goals and methods must be discussed and their consequences for clinic programs traced. Finally, there are a number of practical questions to consider: what professional training is needed by the clinical staff in order to carry on this kind of work? What is required of the communities in which the clinics are held? What are the pros and cons of "community education"? These and other questions will be considered in this and the subsequent chapter, in an attempt to point out the basic issues that the thinking and experience of child guidance workers have revealed.

PSYCHIATRIC PRINCIPLES BASIC TO CHILD GUIDANCE

In an earlier chapter the general theoretical positions of Meyer and Freud with respect to child psychiatry were summarily described. It was shown there that Meyer's basic contribution was his emphasis on the uniqueness of each individual patient and the consequent necessity of studying his total life history as well as his intellectual and physical equipment if one is to understand the nature of his present disorder. That point of view is based upon the assumption that mind and body are not discrete, and that mental activity and behavior represent the adjustment of the individual as a whole. From Freudian theory came the concept of the dynamic influence of the emotions (the individual's own and those of the persons with whom he is in contact) on human behavior. Freud showed behavior to be purposive but its motivation often non-rational and unconscious. Equally important, as

noted before, he showed that each individual has a capacity for self-direction and that the most therapy and education can do is to provide the setting favorable to the development of latent abilities. This latter concept was elaborated upon and given a somewhat different theoretical basis by Rank. His emphasis upon the constructive capacities of the human will and upon the therapeutic necessity of working with the patient in regard to his present feelings rather than his past experiences has tended to create a third school of thought among child guidance workers.

There are certain common elements in the systems of psychiatry developed by these three men that set them apart from the psychiatry that treats of the diseases of the physical organism. It seems worth while to describe some of these in detail, since so much of our further argument concerning the services to be offered by clinics and the professional equipment required of its staff members depends upon them. First of all, there is the basic proposition that the individual human being is not something acted upon by internal and external forces, but is himself the actor, selecting, eliminating, adapting to his use the events that take place within and outside of his body. As Schilder says, "experience is not mechanical intrusion of the outward world into a passive organism and personality."¹ Meyer suggests much the same point of view when he notes that "mind is sufficiently organized living being in action."²

It follows, therefore, that behavior is meaningful. Whatever a person does—whether he plays truant or sees visions—is not the chance reaction of an organism favored or abused by internal chemistry or external circumstances, but a mode of adjustment of what Meyer calls an integrated "physico-

¹ Paul Schilder, "Personality in the Light of Psychoanalysis," *Psychoanalytic Review*, Vol. XXII (1935), p. 40.

² Adolf Meyer, "The Role of the Mental Factors in Psychiatry," *American Journal of Insanity*, Vol. LXV (1908), p. 43.

chemical, biological, psycho-biological, . . . intrinsically social . . . individual, the heir, structurally and culturally, of a succession of civilizations."³ The symptoms of a patient—whether he is a psychotic adult or a young child who is considered too naughty or too good—therefore represent attempts to solve the difficulties which he finds within himself or in the outside world. He may submit to these difficulties in meekness or fight against them in wrath; he may propitiate them with good behavior or deny them and invent a better reality. The ways of meeting adversity are as numerous as the individuals concerned, and often their exact meaning can never be known. Nevertheless, the psychiatrist of the dynamic school does not consider behavior adequately accounted for by a diagnosis, for even in an organic psychosis he finds that many of the patient's actions are a derivative of his total personality and represent his response to the new internal situation.

A necessary corollary of this proposition is that treatment of psychological disorders can rarely be confined to symptoms alone. If the behavior is the type that can be forbidden or about which the child can be made too unhappy, it is very likely that if he does curb that activity he will find some other mode of conduct equally indicative of his inner disturbance. In addition, the thwarting of a symptom without other constructive change may make the real disorder worse. As Ernest Jones has pointed out, "The phenomena comprising a mental disorder are symptoms . . . in the modern sense of indicators, but they are indicators, not so much of disease, except by implication, as of a healing process. . . . They are the products of an attempt to heal the underlying disease."⁴ Ac-

³ Adolf Meyer, "Growth of a Scientific Understanding of Mentality and Its Relationship to Social Work," *Proceedings of National Conference of Social Work*, 1923, p. 196.

⁴ Ernest Jones, "Psychoanalysis and Psychiatry," *Mental Hygiene*, Vol. XIV (1930), pp. 392, 393.

cordingly, attempts to block the solution, however pathological it may appear to be, are not warranted unless some help can be given to relieve either the outer or the inner stress.

Therapy, however, consists not only of ways of giving help but must proceed from a sound understanding of what is involved in a patient's taking help. It is in this area that the most recent advances in dynamic psychiatry have been made. On the one side, this new knowledge is based on an increasing appreciation of the constructive forces in the individual psyche, conscious as well as unconscious. Freudians pay greater attention than formerly to the problem of "ego strengthening,"⁵ while Rankians base their therapy on the forward-looking propensities of the "positive will." On the other, less theoretical side, the question of taking help centers around the simple observation that patients have minds of their own, that they do not always accept even the help for which they appear to be asking, and that they do not always use that which they appear to have accepted. The basis of these reactions in the fear of a loss of self-identity and the feelings that accompany it have recently been convincingly summarized by Grace Marcus:

The average individual has many reasons, both rational and irrational, for reluctance about being helped. It may seem like signing a mortgage on his own soul, and on his freedom of action, a more unwelcome mortgage because its amount and its terms are indefinite and the mortgage-holder's stake in the bargain remains disquietingly vague. Another source of uneasiness about asking help lies in the feeling that the very act of requesting it may pre-commit the seeker to take whatever is given and may trap him in the falsehood and humiliation of having to appear to accept something inadequate or inappropriate and to swallow his disappointment and resentment about not getting what he wanted. The fear of help is the fear of interference

⁵ See Anna Freud, *Ego and the Mechanisms of Defense*, London, Hogarth, 1937.

with our own autonomy, however shaky that may actually be. It is the fear of some loss or weakening of our own identity; though that identity may be painful, our only reason for clinging to life or reality rests in our still attributing some importance to a self without which our particular living becomes unimaginable.⁶

A therapy that does not proceed from an understanding and acceptance of these feelings and a method of turning them to positive account is bound to dismiss many patients as resistive or uncooperative. In addition, an examination of the implied tenets of such a therapy suggests that its objectives are those of remodeling the individual for the social good.

The method of treatment that is the logical derivative of these propositions about human psychology places chief reliance upon bringing to light the patient's feelings about the situation in which he finds himself and in accepting these in a non-judgmental manner. This material is utilized differently by the various schools but all appear to be in agreement that to obtain it is the basic requirement for therapy. Meyer, for instance, writes:

In our study and in our work we do not impose upon ourselves any artificial limits or fixed standards of interest in the human aspect of our subjects. . . . We have to understand the person's habits and capacities and ambitions, no matter how different they may be from our own, and we have to learn to help, not to meddle.⁷

From this it follows that the practice of psychiatry is necessarily more of an art than a science. The psychiatrist cannot depend upon standardized interviews and tests for obtaining information, nor can a textbook knowledge of human motivations be a substitute for an intuitive approach to a patient's needs.

⁶ Grace Marcus, "Case Work and Mental Health," *The Family*, Vol. XIX (1938), p. 102.

⁷ Adolf Meyer, "Growth of Scientific Understanding of Mentality and Its Relationship to Social Work," *Proceedings of National Conference of Social Work*, 1923, p. 197.

Except for agreeing on this basic approach to the patient and his problems, psychiatrists differ considerably in the use they make of such data and the further conduct of treatment. Since there is no generally accepted division into schools and considerable overlapping of methods throughout any division that might be attempted, it seems useless to try to discuss differences on that basis alone. There are, however, several cleavages within child guidance and between it and other types of child psychiatry that may be noted because of their bearing on any proposed program's policies and services.

DIFFERENCES BETWEEN CHILD GUIDANCE AND OTHER FORMS OF CHILD PSYCHIATRY

Aside from child guidance, child psychiatry may be broadly considered as of two types. On the one hand, there is the child psychiatry that is the definite outgrowth of non-Freudian adult psychiatry, the application of the same general principles to the child patient. Most crudely described, this consists of examining a child's assets and liabilities (psychic, psychological, physical, and social) and prescribing a regimen by which they may be developed and corrected. Sometimes the child himself is treated—that is, told about the findings and encouraged to correct his disabilities; sometimes the parents alone are informed and advised. The following excerpts from Kanner's *Child Psychiatry*⁸ are illustrative of this approach. Starting with the correction of all physical ills and the establishment of satisfactory rapport, Kanner recommends the following procedure in treating the child:

The correction of faulty attitudes and notions which the child has formed with regard to his personality disorder. . . . It is not enough that we know ourselves that the difficulty which we wish to remedy is a whole function of the patient's personality;

⁸ Leo Kanner, *Child Psychiatry*, Springfield, Ill., Charles C. Thomas, 1935, p. 121-28.

we must formulate our information to the child who is old enough and intelligent enough in an intelligible and constructive manner. . . .

Create in him confidence in ourselves as well as self-confidence in his ability to overcome the difficulty. . . . Let him know we think well enough of him to "let him in" on the program which is worked out together with him as well as for him, and that we expect him to take an active part in its materialization.

The other general type of treatment, aside from the methods developed by child guidance workers, is that of psychoanalysis. In both theory and technique these two methods of treating children are at opposite poles (the one strengthens conscious desires, the other seeks to allay unconscious conflict; the one proposes definite, concrete modes of change, the other makes no suggestions regarding a way of life), but they have in common two attributes that distinguish them from child guidance. One is their conception of the role of the parents in the treatment process. A corollary of that is their use of the social worker. In order to make clear, then, just what we mean by child guidance work, it is necessary to describe these distinguishing characteristics in some detail.

While it is incorrect to generalize completely regarding this subject, it appears fairly accurate to say that the child analysts concentrate their attention almost wholly upon their patients and consider parents chiefly as sources of information or as persons whose cooperation must be maintained if the children are to continue treatment. Burlingham,⁹ for instance, writes in one of a series of articles on child analysis edited by Anna Freud:

The child's emotional relationship to the analyst is complicated by many factors, among them his natural attachment to and dependence upon his parents. In turn, his dependence upon his

⁹ Dorothy T. Burlingham, "Child Analysis and the Mother," *Psychoanalytic Quarterly*, Vol. IV (1935), pp. 69, 75-76.

parents forces the analyst to keep the child's parents in a favorable attitude toward the analysis. . . . To maintain the sympathy and cooperation of the parents throughout the entire analysis of a child is a difficult and trying problem; and yet if one does not succeed in this the analysis moves inevitably to an abrupt and premature interruption. . . . Mothers in general, therefore, have to be dealt with as a part of the treatment. They must be appealed to and their interest must be gained.

She goes on to say that some analysts ignore the mother, others require that the child be placed in a foster home during treatment. For herself, she thinks it necessary to deal with the mother directly, and she recommends interpreting the steps in the analysis to the mother, enlisting her interest in treatment by having her report upon the child's activities and attitudes, and utilizing her natural feeling of guilt so that she will turn to the analyst for help in undoing the harm she has done to the child.

Kanner,¹⁰ too, puts much emphasis upon securing the parents' cooperation, so that they shall "do something directly for their offspring and more indirectly work on themselves in his behalf." Therefore the following suggestions for dealing with them are made:

The existing problem must be formulated to the parents frankly but tactfully, in simple and understandable everyday language, devoid of professional terminologies, in an inoffensive manner which would assure acceptance. . . .

Treatment should be planned with the parents and not dictated to them. They are entitled to know why certain recommendations are made. Advice must be concrete and palpable, given best in the form of a program for the twenty-four hours of the day. Every step must be made to appear logical, reasonable, and helpful.

Other suggestions include not arguing with parents, not blaming them, correcting their faulty notions, keeping within

¹⁰ Leo Kanner, *op. cit.*, p. 127.

the limits of their modifiability, and arranging for their treatment if necessary. Parents, that is, stand somewhere outside the treatment process. Recommendations are tempered to their frailties, but it is the psychiatrist's opinion of what should be done for the child that is important.

In contrast, child guidance clinicians early came to the conclusion that the parents as well as the children were their patients. Stevenson and Smith¹¹ write:

It has been recognized from the early days of child guidance that the close involvement of the child with its parents, and especially with its mother, make treatment of the mother an almost inevitable concomitant of treatment of the child.

As child guidance work developed, this question of service to parents assumed increasing importance. The dictum "for every problem child a problem parent" became generally accepted, and child guidance seemed at one time to be on the way to becoming parent guidance instead.

This shift in emphasis entailed great changes in the role of the social worker in the clinic, for most of the work with parents was left to her. A survey of the Institute for Child Guidance in 1932 (at that time the chief training center for child guidance workers) showed that in two-thirds of the "full-study" cases the psychiatrists had no interviews with the parents and that in only about three per cent of the cases was a parent seen by a psychiatrist for more than five interviews.¹² More significant was the fact that many children did not receive psychiatric treatment. The same study showed that in a third of the "treatment cases" carried between 1927 and 1930 the children had less than three interviews with the psychiatrist, this proportion increasing to two-thirds for children under nine years of age.¹³ A survey of the work of the

¹¹ George S. Stevenson and Geddes Smith, *op. cit.*, p. 91.

¹² Helen Leland Witmer and Students, "The Outcome of Treatment in a Child Guidance Clinic," *op. cit.* (Ch. X, n. 31), p. 378.

¹³ *Ibid.*, p. 380.

treatment division of the Judge Baker Guidance Center for 1932 and 1933 showed a similar situation.¹⁴ In other words, treatment was carried on very largely by social workers through work with parents, teachers, and social agencies, and in some cases with the children themselves.

The method of child psychiatry which is characteristic of many hospital clinics does not, of course, dispense with the social worker. Growing as it did largely out of Meyer's work and teachings, it follows him in deeming her services quite indispensable. But the emphasis in such social work is on gathering information to round out the psychiatrist's picture of the child's environmental situation and on "follow-up" work to see that his recommendations are understood and carried out. Kanner,¹⁵ for instance, writes:

A competent social worker can do a great deal [toward] helping the family to carry out the physician's recommendations and can save much of his time by working out a direct contact with the child himself. The psychiatric social worker is not only an "investigator," but a valuable therapeutic agent. . . . A good social worker is a decided asset and no child psychiatrist can afford to be without one.

Child guidance started with similar conceptions as to the social worker's role in treatment. But along with the finding that children's problems can usually be traced to adverse parental attitudes, and with the attempt of the social workers to treat the parents, came the recognition that parents too are people and that the principles of dynamic psychiatry apply to them as well as to the children. It followed that if the social workers were to treat the parents (in contrast to the older method of merely securing information from them and advising them of the clinic's findings) they would have to

¹⁴ Margaret Quick, unpublished thesis, Smith College School for Social Work, 1935; on file in Smith College Library. Published in abstract form in *Smith College Studies in Social Work*, Vol. VI (1936), p. 281.

¹⁵ Leo Kanner, *op. cit.*, p. 135.

learn much from the psychiatrists about theory and techniques. A detailed analysis of the steps of the process by which psychiatric social work changed from a history-gathering to a treatment basis would take us too far afield here.¹⁶ It seems sufficient to point out that various methods for the treatment of parents were slowly worked out, most of them proceeding from a desire to alter the parents' attitudes in order that the patients would have a more favorable emotional environment. It was believed that some parents could accept and profit from advice and suggestions. Others seemed to need "education"—a kind of tutorial instruction regarding the emotional needs of children, their own children's motives and desires being particularly interpreted to them. Again it was held that certain parents could best benefit from gaining insight into their own personal problems, while for the few who came to a clear recognition of their need for help and a desire for it "attitude therapy"¹⁷ was designed. On the other hand, it was recognized that some parents could be helped by what was called "supportive treatment," which aimed not so much at changing them as at lessening their anxiety about their children or diverting some of their attention.

So stated, this description of techniques puts undue emphasis upon the social worker's preliminary planning and does not give consideration to the fact that in practice she more or less followed her patient's lead and tried to adapt her methods to his desires. Through the latter process it became increasingly clear that parents could not be changed to order nor could another person plan for them how they should conduct themselves in regard to their children. As recently summarized by Bertha Reynolds, the situation seemed to be about as follows:

¹⁶ For a historical account see Virginia P. Robinson, *A Changing Psychology in Social Case Work*, Chapel Hill, University of North Carolina Press, 1930.

¹⁷ For a description of this particular method, see David M. Levy, "Attitude Therapy," *American Journal of Orthopsychiatry*, Vol. VII (1937), p. 103-13.

The final choice of a course of action, expressed as behavior, is a resultant of many forces—out of the person's past, as well as his environment in the present, and out of his world of ideals and his hopes for the future. A case worker who understands that this is true of everyone—not least of himself—knows that he cannot be the controlling force in the decision about what to do with some problem in the life of another.

The case worker must discard, then, any sense of god-like superiority to these other influences, and must study them with the most accurate observation and the finest sensitivity to what the unconscious of the client is saying when it speaks through the disguises of behavior. Only by this carefully controlled process may the case worker discover what place he actually has among the forces that determine the client's feeling and action. It is the client, who has all his life been gathering up into a knot these strands of influence, from within and from without himself, who is the only one in any position to use the case worker (who is just one more influence) in balance with the rest.

If we accept the foregoing as true . . . the futility of coercion becomes increasingly evident. It is no longer a question of whether it is wrong to try to make our fellow beings think and feel as we want them to. In the long run it is simply silly.¹⁸

Accordingly, there has been a slow shift in the thinking about case work with parents, and the present trend seems to be toward a clarification of case work and the kind of help it can offer, and of its distinction from psychiatry. While many child guidance clinics still plan the handling of a case in terms of whether or not the attitudes of the parents (particularly the mother) are in need of change and, if so, what methods can be used to effect the desired alteration, others are coming to state their function more specifically in terms of the guidance of children. In such clinics the social worker's help is made available to parents not because the clinic aims to change their attitudes but because the parents are likely to be worried

¹⁸ Bertha C. Reynolds, "Re-thinking Social Case Work," *Social Work Today*, May 1938, p. 5.

about their children and to want an opportunity to talk to a professional person about them. The objective thus becomes one of providing a helping situation in which the parent may be able to express his feelings about his child and mobilize his capacities for deciding what he will do about the problem. Since the purpose of the clinic is *child* guidance, this help to parents is offered, of course, in the child's behalf—in the belief that the child will be benefited if his parents are able to be more comfortable in their feelings about him. There is, however, an essential distinction between this attitude toward parents (which recognizes that the children are theirs, and the decisions about their care therefore are for the parents to make) and that which allies the clinic with the child and looks upon parents as part of the environment that may need to be altered. Under the former conception, case work treatment remains strictly within the area of the clinic's function—*child* guidance—and does not attempt to help the parents solve their own personality problems.

There thus appear to have been two major contributions which the child guidance movement has brought to child psychiatry in addition to its methods of treating children which will be described below.¹⁹ In the first place, the findings of dynamic psychiatry are applied to work with parents, and their wishes become the focal point from which treatment proceeds. Consequently, the original conception of the function and work of the social worker has been greatly altered, so that she has become not the aide but the colleague of the psychiatrist in an undertaking that usually involves

¹⁹ Psychiatric treatment of even young children appears to be on the increase, not only in the privately supported urban clinics, which presumably have more freedom in limiting their intake, but in some state-supported ones as well. This trend has been noted, for instance, in recent reports of the Illinois Institute for Juvenile Research and the Massachusetts Habit Clinics. An indication of this trend was seen in the program of the 1938 meeting of the American Orthopsychiatric Association, where "play therapy" and other methods of psychiatric treatment of young children formed one of the chief topics of discussion.

work with several people. These distinctions set the child guidance clinic apart from other methods of psychiatric treatment of children and—left unarticulated—account for much of the current misunderstanding between child guidance workers and those who seek to treat children in other ways.

CONSEQUENCES OF IGNORING THESE DIFFERENCES

Since our survey showed that many state-supported clinics are conducted in accordance with principles which differ from those of current child guidance and that there is considerable dissatisfaction with their practices both within and outside the clinics, it seems worth while to describe in more detail the alternative viewpoints and practices and some of the ensuing consequences. The most frequent situation in which misunderstandings arise is that in which the psychiatrists maintain that mental health is best served by keeping the treatment planning strictly under medical auspices. Under this conception (from which Kanner, above, probably diverges somewhat to the left) the person or social agency referring a child to a clinic thereby puts him in the psychiatrist's hands, anticipating the same type of service he would receive from a medical practitioner. The referring party's duties consist in supplying information about the child and following the clinic's advice after a thorough study of the child has been made. Within the clinic the division of function between psychiatrist and social worker is clearly defined, the latter's services consisting chiefly in supplementing the history material supplied by the referring persons, perhaps interpreting the psychiatrist's findings to them, making various sorts of arrangements with other agencies in the community that will facilitate the carrying out of the recommendations. Since many patients come to the clinic on referral from case work agencies, these duties can be assumed by the agencies, and the clinic does not need a large staff of social workers. If the patient appears to need

psychiatric treatment, he returns as to a medical clinic, and again the clinic social worker's or the referring agency's function is held to be limited to making arrangements for the patient's visits.

It has been shown in previous chapters that such conceptions of child psychiatry procedures are particularly characteristic of outpatient clinics of hospitals. With them goes a tendency to define psychiatric treatment in terms of psychobiological study and diagnosis, the control over decisions being kept as much as possible in the physician's hands. This, however, is not necessarily so, for under this procedural concept the psychiatrist may use any method of work with his patients, excepting only that which requires the type of work with the family that has been described above as characteristic of child guidance clinics. Since, however, the tendency in psychiatric social work is to base training upon psychiatric theory that leads to work of the latter type, a basis for dissatisfaction within the clinic staff is early laid. Similarly, some of the disapproval of clinics which our investigators found among case work agencies probably springs from the same source. Many agencies—for theoretical reasons that have been discussed above—look upon the psychiatric treatment of a child as a cooperative enterprise that involves work (either through them or through the clinic social worker) with the whole family. They may look to the clinic to guide them in their work or they may think in terms of functional differentiation among agencies,²⁰ but in either event they are not likely to be satisfied if the clinic takes the case entirely out of their hands or closes it with a diagnosis.

In one of the hospitals whose work was described to us in the course of our survey (a private metropolitan hospital with

²⁰ See discussion of a case by Rose Green and Annette Garrett, *American Journal of Orthopsychiatry*, Vol. VII (1937), pp. 405-8 and 422; also Rose Green, "Inter-agency Use of Child Guidance Clinics," *American Journal of Orthopsychiatry*, Vol. IX (1939), p. 170-78.

an excellent reputation for psychiatric work) just this situation was found. The chief of the outpatient social service had had long experience in child guidance work, while many of the psychiatrists (they greatly outnumbered the social workers) were trained in a hospital that utilized social workers infrequently. The difficulties encountered in their attempt to work together were clearly traceable to the differences in viewpoint with respect to the clinic's responsibilities toward the patients' parents.

It had been agreed that during one year the social service department would accept any cases referred to it by the psychiatrists and make no attempt to change procedures. It was found that much of what the psychiatrists wanted from the social service department was of the "slight service" type—finding employment or recreational facilities for patients, securing their admission to sanatoria or convalescent homes, modifying public welfare agencies in the patients' behalf, and the like. All of this, it was agreed, lay clearly within the social worker's function. In the work with the families of child patients, however, the differences in the psychiatric assumptions of the two groups of clinicians appeared. It was agreed that the mothers (or fathers) of child patients were to be referred to the social workers for case work treatment, but it was noted that this referral seldom came at the beginning of the child's treatment but only after it had reached a point at which the parent wanted to withdraw him from treatment, or some other such difficulty occurred. The psychiatrist, for instance, may have been interviewing the mother occasionally on an informal basis after case work treatment had begun, it being not uncommon that he would at that time give some advice to the mother about the care of the child or make inquiries of her that might contain implications regarding her attitude toward her child and herself. Then because the child began to object, or for other reasons, the psychiatrist would

stop seeing the mother and would refer her to the social worker. In addition, various procedural difficulties arose (such as making appointments without reference to the social worker's schedule and closing cases without consideration of the case work situation) that testified to a difference in the conception of the place of the parent in treatment. Similarly, difficulties were encountered in the "cooperative work" with social agencies. The psychiatrists considered it the social worker's function to interpret their findings to the social agencies, but the agencies, which had well-trained psychiatric social workers on their staffs, felt no need of such interpretation and wanted consultative conferences with the psychiatrists instead.

It has seemed worth while to describe this situation in detail, for it shows the consequences in practice of attempting to mingle two different conceptions of psychiatric work. It is maintained, on one hand, that psychiatric social workers tend to overstep their boundaries in attempting to treat their clients' problems, and it is claimed, on the other, that many psychiatrists disregard the feelings of their patients' parents. There may, of course, be truth in both statements but it seems also likely that differences in the theory of treatment lie at the base of the difficulty. Which theory produces better results in terms of the children's mental health is a question to be answered by research, if at all. It is the conclusion of our observations, however, that attempts to mix the methods—so that one part of a clinic's staff proceeds upon one set of assumptions and the other on another—lead only to confusion and lowered morale, which is probably communicated to the patients in one way or another.

CLEAVAGES WITHIN THE CHILD GUIDANCE FIELD AND THEIR CONSEQUENCES

We have seen above that, in spite of having many basic psychiatric principles in common, the various forms of dy-

dynamic child psychiatry exhibit important differences and that child guidance has a set of distinctive characteristics. There are, however, cleavages within the child guidance field that have important consequences for the work of clinics. One of these is based on differences of opinion concerning the goal of treatment. Another, cutting across the first, grows out of differences with respect to treatment methods and leads to divergent conceptions regarding the relation of a clinic to the various agencies with which it works, and even regarding the basic function of the clinic itself.

Concerning the goal of treatment

The introduction of the concept of promoting mental health, as White said, "because of its present values and not because of what it avoids" necessitates a subtle shift in viewpoint that has not always been made explicit, particularly in state-supported clinics. Mental hospitals and penal institutions have traditionally been operated more for the benefit of society than for their patients. In so far as they have aimed to cure or rehabilitate their charges, they have been chiefly motivated (the penal institutions doubtless more than the hospitals) by social objectives. Accordingly, any means that within relatively humane limits gave promise of preventing the recurrence of the behavior that precipitated institutionalization has been viewed with favor. It was expected at one time, for instance, that delinquents could be scared into good behavior, and if the system has now changed to one of education, the aim generally remains the same—that of protecting society from further inconvenience and damage. With the mental hospitals the case is not quite so clear-cut, but by and large these institutions too have been more concerned with giving custodial care to those who are potentially dangerous to society than with helping the mentally disturbed to work

out their problems or find some more satisfying mode of existence.

This social aim, it has been suggested in previous chapters, was carried over into clinic work, for clinics were originally conceived as extensions of hospital or other institutional service. Patients were to be studied before their condition became so extreme as to necessitate institutionalization, and financial support for the clinic movement was secured largely through the implicit promise that society would benefit. The clinics thus became another part in the institutional apparatus of schools, churches, courts, and so on, which molds the individual to society's needs.

At first thought that aim appears to be perfectly legitimate, and the implied incompatibility of social and individual objectives seems unjustified. The resolution of the paradox that the socially maladjusted individual can best be helped by one who is not motivated by social aims is to be found in modern psychiatric theory, which sees emotional growth as proceeding from the resolution of conflict and not from the imposition of authority, no matter how kind it may be. Some of the details of that theory will be described below. Here are to be noted first some of the consequences of the practice of a psychiatry that arrays itself with the other regulative institutions.

The influence of the conception that the clinic is set up to bring about the readjustment of children to the ways of the group is shown first in the criteria used in selecting children for treatment. These are based primarily upon definitions of maladjustment. Children with such and such characteristics are the ones who should be referred to the clinic, the conception of what constitutes maladjustment being extended as "normal" behavior is more rigidly defined. Accordingly, clinics tend first to receive large proportions of mentally de-

fective or aggressively antisocial children as patients and only gradually teach the community to recognize shyness and withdrawn behavior as also symptomatic of maladjustment. Such criteria put the emphasis in clinic referrals upon those who need treatment, not necessarily upon those who want it. In consequence, the initial decision to enlist the clinic's help is not left to the persons most immediately concerned (the patients and their parents), but comes usually from those who find the children troublesome (the schools, the courts, and the social agencies). It follows, therefore, that many patients come to the clinic under circumstances that prevent them from receiving the help they need and that the cards are stacked against carrying out the purpose for which the clinic exists.

In regard to the first point, the selection of patients by persons in position of authority over them frequently presents the clinic to the children in a most unfavorable light. Clinics have found this to be particularly true of court referrals, in which both children and parents usually come because they feel there is no alternative. Not that under present circumstances, at least, referrals to clinics should not come from persons outside the family (the knowledge of psychiatric resources is confined to too small a group in the community for such a decision); the frustrating limitation is that most of these referral sources interpret the clinic in terms of the removal of objectional behavior. That such an aim should be resented by many children who are already in conflict with organized society is clearly understandable. The clinic may make a reinterpretation of its objective when the patient or his parents are first interviewed, but frequently they are not even then really free to accept or reject the clinic's help, for their attendance at the clinic is often the price they must pay for the continuance of the child in school or out of a penal institution. The old aphorism about leading a horse to water

applies here. The aim of social reformation through clinic treatment thus tends to be self-defeating, for the lodging of the decision as to who needs treatment in the hands of those who most stand to benefit by it creates conditions that make a successful outcome by any standards unlikely in many cases.

Since by the profession of such an aim the clinics lay themselves open to adverse criticism if they do not achieve a high proportion of favorable results and since they are probably loaded with patients who cannot accept their help, they are forced to methods that tend subtly to shift the blame for failure. The working philosophy of most such clinics is that after thorough study of the case the staff can make a plan which, if carried out, is expected to restore the patient to a position of social acceptability. Under such a conception much emphasis is put upon the removal of undesirable behavior symptoms, and treatment recommendations usually consist of specific things which various persons are to do for the child: put him in another home or change the present one, remove his tonsils, give him spending money, enroll him in camp or the Y.M.C.A., give him more recognition in school and more (or less) attention at home, and so on. With the responsibility thus shifted from both clinic and patient (and usually put upon the home), the way is clear for accounting for failure in terms of "uncooperative" parents. Moreover, if the treatment plan is carried out and the patient does not change in the way that is considered desirable, a philosophy which makes the patient the passive receiver of the kindly ministrations of those who know what is best for him leads next to the conclusion that the patient is particularly culpable. He was originally maladjusted, and by his refusal to change when conditions are presumably made pleasant for him he shows himself really unworthy and is classified as "untreatable." The clinicians, it is true, may not view the matter in so moral a way, but there is much evidence that that tends to

be a community's reaction, especially if the clinic's program has been described as a means of salvaging wayward youth.

Child guidance clinics that are psychiatrically sophisticated may not exhibit so crudely the desire to remodel the patients to their own standards, but it has been pointed out by Jessie Taft²¹ that there is an element of the reform spirit in most clinic programs. Some years ago she wrote:

For some the norm is maturity, for some independence, for some social conformity, and for others personal happiness, but in the majority of cases psychiatrist and case worker are at bottom wedded to the responsibility for changing other human beings for their good, with or without their consent, in accordance with a more or less conscious, more or less personally determined standard of what an individual should become.

The alternative to this point of view about child guidance work is one that sees the treatment process as aiming so to strengthen the patient that he will be able to work out his own kind of adjustment less handicapped by emotional turmoil. Such a concept holds forth no promises of good results in terms that are previously determined upon by the therapist. It recognizes that there are myriad ways in which individuals find satisfaction in life. The clinic, under such a conception, takes responsibility only for its professional skills and their utilization, holding that the patient's ability and desire to benefit from them will vary with many circumstances that lie outside of the clinic's control. That such a point of view does not lead to psychological nihilism is due to the counteracting belief that under reasonably favorable circumstances each human being contains within himself forces that favor his social adjustment.

The theoretical basis for this faith in the ability of the patient to make his own way varies with the schools of

²¹ Jessie Taft, "A Consideration of Character Training and Personality Development," *Mental Hygiene*, Vol. XIV (1930), p. 330.

thought, but it seems to be a concept that is common to all forms of dynamic psychiatry. About this Meyer is not very explicit but he refers frequently to the "adaptive mechanism" and the various kinds of adjustment which it is to be expected different individuals will make. In one article that seems to summarize his position well, he called the brain the "organ of behavior" and the mental reactions "functions of behavior." "Behavior," he wrote, "is regulated by feelings, by fears and desires, by knowledge and wisdom, by personal desire and social custom or social laws. . . . Whenever the functions or the organ of behavior become morbid or sick it is because the one or the other of the adaptive functions becomes unruly, unable to balance, over-assertive or too little assertive." The mechanism of adaptation or behavior may become upset through disorders of special organs or "taxing mental states, excessive and abnormal cravings and preoccupations, and ill-adapted emotional attitudes." From such a condition the normal individual can "find his balance again spontaneously" but "other less well-endowed persons get more easily into conditions which do not adjust themselves without special helps and precautions."²² Although there is much in Meyer's theory of therapy which implies that the control of treatment should be in the therapist's hands, his doctrine of "meliorism" shows that he would not have the therapist lay down specific modes of adjustment for his patients. As Meyer says, "There is no room for perfectionism in modern psychobiology. . . . Our philosophy is content to be a sound meliorism with faith in human effort."²³

Freudian theory has more to say about why it is impossible

²² Adolf Meyer, "The Aims of a Psychiatric Clinic," *Report on the Care and Control of the Mentally Defective and Feeble-minded in Ontario*, 1919, Appendix S, p. 224-25.

²³ Adolf Meyer, "Growth of Scientific Understanding of Mentality and Its Relationship to Social Work," *Proceedings of National Conference of Social Work*, 1923, p. 198.

for the therapist to prescribe a way of life and why the patient, in working out his own solution to his problems, will tend to arrive at a mode of functioning that is socially acceptable.²⁴ The first is a derivative of the theory that much of each person's emotional life is unconscious and that even on the conscious level the meanings and values of any experience are peculiar to the individual and not wholly ascertainable or understandable by any other person. Present decisions and actions represent such a complex of motivations and feelings, many of which extend into the patient's forgotten or repressed past, that it is obviously impossible for one human being to know what would be the best course of action for another to pursue. On the other hand, Freudian theory holds that when not too much handicapped by external requirements (and their internal replicas in anxiety and guilt) each individual in his own peculiar way tends to integrate his instinctual energies with social requirements. This happy solution to what at first appears to be an irreconcilable conflict between native instincts and society's demands arises from the fact that under favorable circumstances the demands of society do not remain an alien force, but early become an integral part of the personality. The normal process of progressive understanding of the environment and adaptation of instinctual energies to its utilization is blocked only by situations that turn the instinctual forces inward and create emotional conflict.

Otto Rank's point of view is also important here, for his influence on child guidance work in America has been considerable. His system of psychology²⁵ differs in many impor-

²⁴ For a discussion of the Freudian point of view with respect to the curative tendencies within the individual, see Herman Nunberg, "The Will to Recovery," *International Journal of Psychoanalysis*, Vol. VII (1926), p. 64-78. The Jungian school also holds to this point of view. In this connection see Alphonse Maeder, *Auto-Guérison dans la Vie de l'Âme*. (Publisher unknown.)

²⁵ It is impossible to summarize Rank's system adequately, but it might be noted that in his opinion a neurosis is not a disease but a maladjusted relation-

tant respects from that of Freud but he too holds—perhaps more explicitly than Freud—that the patient can only be helped to find his own solution to his difficulties and that the therapist “must refrain from moral evaluation of every kind.” His concept of the therapeutic problem and of the reasons why such a philosophy of self-determination does not lead to social chaos is well summed up in the following quotation from one of his books:

It is important that the neurotic above all learn to will, discover that he can will without getting guilt feeling on account of willing. The danger which one might see in this does not exist in reality, for there remain always many regulating factors (repressions and ideals) which restrain him from converting this will of his into action. One can see such a danger in therapy only if . . . he conceives of morality in general as externally determined. Purely psychological consideration would show that it is his own inner inhibitions that make the individual not only moral but even hyper-ethical.²⁶

In the light of these theories of individual needs and capacities, the objective of psychiatric work with children becomes something quite different from attempting to adjust them to the commonly accepted social standards. It is not that they should not be, but that they cannot be, shaped to another's image. The clinic must therefore stand outside the network of regulative institutions and seek recognition in the community as the agency of the individuals who want its help.

ship between the individual and society. Nor is the neurotic a deviation from a social norm: instead he is a type, characterized by the denial of individuality and a failure to find a medium through which he can externalize it. His difficulties arise out of a lack of balance in the organization of his will (the will being conceived as the “supreme autonomic organizing force”), an inability to establish the kind of relationship between impulse and inhibition so that the inevitable internal conflict between them can be projected upon the outside world. The objective of therapy, in Rank's opinion, is not to secure social conformity but to “help the patient to will without guilt.” For a brief account of the theory, see Pearce Bailey, “An Introduction to Rankian Psychology,” *Psychoanalytic Review*, Vol. XXII (1935), p. 182-211.

²⁶ Otto Rank, *Will Therapy*, New York, Alfred A. Knopf, 1936, p. 14.

Concerning the methods of treatment

Another set of differences that has important implications for clinics that aim to promote mental health is found in the varying conceptions of the role of environment in therapy and consequently of the clinic's relationship with other agencies of the community.

Granted that child guidance treatment rests on the understanding of a child's desires and capacities, there still remain several methods by which the patient may be helped to a more satisfying mode of adjustment. A survey of current practices reveals four general types of approach. In the first place, much of the work of many clinics centers around attempting to make the environment an easier or pleasanter place for the patient to live in. This may take the form of providing a new environment for him or attempting to remodel the old one. Included in this method are such diverse activities as those aimed at modifying parents' attitudes or relieving their tension and those of "interpreting" the child to his teachers and other adults, various other kinds of modification of the school environment, foster-home, or institutional placement, and the like. Directed toward the patient rather than toward the environment is the approach that attempts to find new outlets for the patient's energies or capacities—the building up of new recreational interests, the fostering of undeveloped talents, the encouragement of activities in which he is likely to find success. This involves the community in so far as it calls upon it to supply recreational and other resources. A third approach consists of remedying the patient's specific disabilities—physical and intellectual; that is, of removing certain specific internal obstacles so that he is put more on a par with his fellows. Finally, treatment may consist, as described above, of a direct dealing with his

psychic problems, the methods varying with the different therapists.

In practice most clinics use a combination of these four approaches. There is, however, a fundamental difference between at least the first and the last one, so that, depending upon whether one or the other of these is emphasized, the clinic is led to considerably divergent modes of functioning. Stated broadly, the first method may be considered that of adjusting the environment to the individual while the fourth proceeds from the assumption that the patient can make his own adjustment if he is helped to overcome to some extent his anxieties and his fears.

It will be noted that this division among clinics according to their emphasis in method of therapy does not necessarily parallel the one previously discussed that separates them into two groups on the basis of whether or not they attempt to prescribe certain modes of conduct for their patients. Each of these groups may attempt to accomplish its objectives either by helping the patient adjust to the environment or by attempting to meliorate the environment in the patient's behalf, though the tendency among those who emphasize self-direction will perhaps tend to favor psychotherapy. Nor does the distinction have any bearing upon the psychiatrist's original approach to the patient. Clinicians of most schools appear to be in agreement that the first aim in therapy is to create a situation in which the patient is free to express what he will without the usual danger of incurring disapproval. The purpose of making the distinction between the approach through the environment and that of personal treatment is to point out the divergent consequences for clinic work.

By and large, modifying the environment is the traditional mental hygiene method. Mental hygiene, it will be remem-

bered, began as a movement to provide a more understanding environment for the psychotic patient, and it eventually moved into the field of child guidance because it found that some of the conditions presumably leading to psychoses were to be found in the misunderstandings and other environmental handicaps by which children are surrounded. It was found that therapy had to proceed upon a case-by-case basis because the needs of children were so diverse, and yet clinic work was widely considered essentially educational. It has been noted in a previous chapter that the early clinics were definitely set up as demonstrations—demonstrations not only of what a psychiatric clinic could offer its individual patients but especially of what the mental hygiene point of view had to offer to the professional public who were responsible for the care of children. The educational aspects of clinic work were always stressed. The staffs gave numerous lectures, and representatives of schools, courts, and social agencies were invited to staff conferences, partly in order that they might learn how to handle some of the problems themselves, for it was generally agreed that clinics could never hope to serve all the children who were maladjusted.

The assumption behind this point of view tends to be that of the "happy savage," for the blame for emotional maladjustment is usually attributed largely to the environment. The theoretical basis for this is found in such diverse sources as behavioristic psychology, certain schools of sociology, and that interpretation of Freudian psychology that places the repressing forces chiefly in the external environment. Regardless of its theoretical assumptions, however, a clinic that bases its work upon changing the individual's environment so that it shall present fewer obstacles to his development is necessarily interested in social and educational reform. In such a clinic the educational and demonstration aspects of clinic work tend almost necessarily to take precedence over the purely

psychiatric, and the clinic comes logically to the position recently set forth by Plant,²⁷ who is inclined to view each clinic patient as a random sample of community neglect. After a detailed description of the ways in which the culture puts unnecessary pressures upon children, to which personality and conduct disorders are a response, he concludes:

The future of therapy, then, does not lie in the multiplying of ever more refined techniques to be administered by ever more specialized technicians, but rather in those procedures which will lead the family, the school, and other social institutions and their vicars to this "medical" view of the conduct of people. It looks to modes of selecting and training these vicars which will insure that they are sensitized to this way of viewing their task. It depends upon the recognition by these vicars of the fact that the "cure" stands patently before them, if they but accept the necessity of altering pressures rather than merely trying to eliminate the distressing conduct.²⁸

The alternative approach of a clinic to its work accepts the world as it is (or at least holds that reform of the community does not lie within its function) and concentrates attention upon helping the patient make his adjustment to it. Some of the assumptions of that point of view have been described above. They include the belief that most individuals have a capacity for self-direction, that the forces making for good or poor emotional adjustment lie largely within the individual, that therapy is purely for the patient and not a means of serving society's ends. Such a clinic will have little interest in reforming courts or schools, holding instead that these institutions serve functions other than those of the clinic and that it would therefore be presumptuous for the clinic to attempt to alter their policies. The help such a clinic can give to other agencies will be limited to what the clinic considers its specific

²⁷ James S. Plant, *Personality and the Cultural Pattern*, New York, The Commonwealth Fund, 1937; especially Chapter IX, f.

²⁸ *Ibid.*, p. 250.

task—understanding the child's feelings and desires. Whether it operates upon a diagnostic or a treatment basis, this it will hold is the limit of its professional capacities, and its relationships with other agencies and its services to them will proceed from that conviction.

To those who view the child guidance clinic as the repository of wisdom about human psychology there is perhaps something frustrating about this second conception of clinic work. Actually, however, a clinic guided by such a concept does not deny to other professional workers any knowledge derived from its special field of competence—the wishes and motives of individual children. It draws the line only at stating to what use other professions and other agencies shall put that knowledge, thus accepting them as it accepts its patients as persons capable of making their own decisions. Nor need such a clinic be judged an apologist for what are generally considered handicapping social and economic conditions. Since it makes no claim to fitting its patients to the environment, it can simultaneously hold that certain conditions preclude the possibility of giving psychiatric help to children, just as a medical doctor can maintain that in spite of the best will on his patient's part he cannot help him to physical health if the environmental conditions are too destructive. The distinction between the two types of clinics lies, then, not in the attitude toward social pathology but in the conception of the clinic's function. In large measure, this eventually becomes a question of education of the community versus treatment of the patient.

TRAINING REQUIRED FOR CHILD GUIDANCE WORK

Such an analysis of the diverse tendencies within the child guidance movement makes it clear that it is impossible to draw up a list of specifications for the services to be offered by a clinic and the specific duties and training of its staff

members. To imply, however, that all theories of child psychiatry are equally tenable would be to deny the validity of the findings of dynamic psychiatry. If those principles about human motivations and behavior are accepted, some generalizations regarding the necessary training of clinic workers can be made. First of all, it is clear that work with children cannot be based to any large extent upon experience with psychotic patients. Child guidance—under any of the procedural forms described above—depends essentially upon knowledge of children's capacities and motivations, their fears, aspirations, and possibilities for growth, and upon ability to utilize this knowledge in a therapeutic relationship. Such knowledge and skills can be acquired only through work directly with children and usually only under trained supervision. Nor do these requirements for training diminish if the clinic is to be set up on a diagnostic rather than a treatment basis. Rather, it could be maintained that to size up a child in a single interview (if it can be done at all) requires much more intuition and skill than the more leisurely process of becoming acquainted with him through numerous visits. Commenting on this subject in regard to short-time contacts in social case work, Bertha Reynolds²⁹ writes:

If we think dynamically about social case work, short-contact interviewing is neither a truncated nor a telescoped experience but is of the same essential quality as the so-called intensive case work. . . . A failure to make a significant contact is not as easily masked by the hope (which does not always materialize) that there will be better success next time. . . . To solve the problem of keeping in the client's hands the responsibility for his own problem there is required a personal security that dares to take responsibility for decisions—where the client needs help, for instance, where stimulation, where temporary protection from responsibility, where diversion until he gets a new grip, where a challenge.

²⁹ Bertha C. Reynolds, "An Experiment in Short-Contact Interviewing," *op. cit.* (Ch. XI, n. 13), p. 106-7.

As to the professional equipment required of social workers, much of one aspect of it has been implied in the preceding descriptions of their work in a child guidance clinic. There it was indicated that two somewhat divergent conceptions of case work treatment are to be found in clinics today. The distinction appears to rest upon the clinic's viewpoint in regard to parents: whether they are looked upon as part of the environment which is to be modified in the patient's behalf or whether they are regarded as the persons to whom the clinic is offering help with the problem (a child's behavior disorders) which the clinic is specifically designed to meet. While this distinction in the approach to the work necessarily has connotations for the training of social workers, there is sufficient common ground between the two points of view to permit some generalizations that apply to both. The essential requirement is that social workers have an understanding and appreciation of parents' feelings about their children and about taking help in regard to their problems and are able to utilize this knowledge in a way that may be of assistance to the parents. Much has been written as to what is involved in acquiring such skills, but we can only emphasize here that case work under any conception of its objectives is a professional undertaking that can seldom be adequately carried on without careful training.

In addition to an ability to work with parents, the social worker needs other knowledge and skills that equip her for the important role she has to play in relation to other agencies of the community. On her rests much of the interpretation of function—of the clinic to the other agencies and of them to the clinic. She must know the community's resources—in terms of both persons and institutions—and be able to work with them in the interest of the patients. While this is an important area of social work in any child guidance clinic, it becomes of particular importance in clinics in which much of

the "follow-up" work is left in local hands. In such a situation the clinic social worker is frequently called upon to assume a kind of tutorial function with respect to the local workers. It has been suggested in previous chapters that many of the difficulties encountered by state-financed clinics and much of the criticism to which they are subjected arise out of their inability to provide adequate treatment services. Various means of supplying this have been tried, but regardless of what policy is followed, it is obvious that the social worker must have a clear conception of her role and a special ability to work with and sometimes through other professional persons.

The function of the psychologist in a clinic with a general mental health objective would probably not be very different from that described in the preceding chapter, in which his work in a clinic for children handicapped by mental deficiency or neurological disorders was described. In the former setting there would be fewer cases in which he would be called upon to supervise the education of the patient but there would be perhaps more in which his knowledge of the means of correcting special intellectual disabilities would be required. The present trend in child guidance clinics appears to be away from all routine examinations, with the result that many patients are not given a psychological test. On the other hand, some clinics are beginning to use their psychologists for therapeutic work, particularly with young children. In either case the work of the psychologist shows signs of changing, in that less emphasis is put upon the formal test and more upon the psychologist's ability to estimate the child's intellectual capacities and limitations in a way that takes into account emotional factors. This requires that, more than ever, the psychologist shall have the same fundamental training with regard to attitudes toward people and understanding of them that is needed by the rest of the staff. Just what his work in

the clinic will be will vary from place to place, depending in part upon the community's resources but, whatever it is, it must be an integral part of the clinic's work, which is to help directly or indirectly to remove the handicaps to children's emotional growth.

This again raises a question about clinic services that has been touched upon above. There it was shown that clinics tend to offer different types of service depending upon whether they conceive their function chiefly in terms of diagnosing or treating children or in terms of improving the community's institutions (schools, courts, recreational facilities, and the like) so that fewer children need treatment. While such a description of aims perhaps exaggerates the distinction (in that few clinicians would agree that their purpose is solely of the latter type), the intermediate position held by most traveling clinics—in which the aim is stated in terms of educating the local people—has much in common with community reform. This distinction in the means by which the mental health of children may be promoted derives in part from differences in the causes of emotional difficulties, as has been indicated above, and in part from practical problems encountered in setting up clinics to serve wide areas. A further consideration of these divergent aims, therefore, takes us into the question of how some of the foregoing concepts of mental health work can be put into practice by state-supported clinics.

CHAPTER THIRTEEN

Planning Effective Psychiatric Service for Small Communities

IT was stated at the outset that one of the chief purposes of this survey was to learn from a study of the state-financed psychiatric clinics—their origins, objectives, policies, and experience—how future programs might be carried on effectively under public auspices. For that reason considerable emphasis has been put upon the difficulties encountered by the present clinics and upon the refinements of theory and practice that have resulted from a quarter-century of thinking and experimentation in child guidance. Such an approach may appear to disregard or underrate many positive accomplishments of the clinics. That they do exist we have abundant testimony, but our study was not primarily an evaluative one. Our aim was rather to understand the clinics in terms of their psychiatric assumptions and their objectives, to observe their modes of functioning in a community setting, and to consider what implications recent developments in psychiatric theory and research may have for them.

Our findings have been compiled particularly for the benefit of those authorities that are contemplating new programs of child psychiatry. That there is ample room for the expansion of psychiatric services for children can be demonstrated in various ways. Of the total 617 psychiatric clinics which in the United States in 1935 accepted children as patients, nearly half were located in cities of over 100,000 population, and even then a third of such cities had no clinic service.¹ Only 7,200 hours of psychiatric service were available weekly in clinics, and much of this time was reserved for work with

¹ These and subsequent figures are from data compiled by Mary Augusta Clark for the National Committee for Mental Hygiene.

adults. State governments were the most frequent source of financial support for clinics (they financed fifty-eight per cent of the psychiatric clinics in the United States in 1935²) but twenty-four states gave no financial help to clinics, and in fourteen states there were no clinics under any auspices.³

For the most part, state governments have been chiefly interested in giving financial support to mental health work in non-metropolitan areas. In 1935 over eighty per cent of the state-supported clinics served small towns and rural communities. Nevertheless there were clinics in only seven per cent of the counties of the United States, and although half of the states provided some clinic service, about two-thirds of all these clinics were held in three states (Massachusetts, New York, and Pennsylvania) in which clinics financed by other sources were also most numerous.

Then, too, the amount of service given by the state-supported clinics was found to be meager. In 1935 two-thirds of the numerous New York state hospital clinics and three-fourths of those of Pennsylvania met once a month or less frequently, while most of the centrally directed clinics of those states held even less frequent sessions. Massachusetts made a better showing in this respect, but it was only in Delaware that clinics were held at fairly frequent intervals throughout the state. With such schedules the service of most clinics was almost necessarily diagnostic in type and the number of children examined annually was seldom large. At least a third of the hospitals examined less than fifty new child patients a year, and a third of the individual clinics examined less than ten. In addition, service tended to be limited to cer-

² The other sources in 1934-35 were: municipalities, 9 per cent; counties, 4.5 per cent; federal government, 0.5 per cent; voluntary, 28 per cent. These figures are from data compiled by Mary Augusta Clark of the National Committee for Mental Hygiene.

³ The situation at the time this book was written was known to be essentially similar to that described here, although exact figures could not be secured.

tain types of children—those that most deviated from average by reason of mental defects or neurological conditions. Not that there were no clinics with more adequate facilities and a wider range in type of patient. Here and there, under various auspices, were clinics that gave a child guidance kind of service to less obviously handicapped children; but they were rare, and the predominating picture was of a restricted service for a limited group of children.

In partial explanation of this situation it is to be noted, however, that many of the present state programs are frankly experimental, and that none pretends to be dealing with the whole problem. Most state hospitals are attempting to give advice about the care of the children whom the public regards as most abnormal and by that means are hoping to reduce the future incidence of hospital patients. Most state governments that finance centrally administered programs view clinics as demonstrations of psychiatric work to local communities or state hospitals or as a means of supplementing local services; others restrict their use to state departments and institutions. The university medical schools and some psychopathic hospitals tend to offer clinics as a means of securing material for research and training, subordinating to these ends the service aspects of the work. In other words, no state has as yet undertaken a comprehensive program for promoting the mental health of children. Perhaps in the present state of knowledge, practice, personnel, resources, and the public's attitude toward psychiatry, it is just as well that this is so. At least such a point of view justifies this study, which has aimed to survey and analyze the present situation in advance of further expansion of the public psychiatric services.

It is obvious that under the diverse conditions that exist in the United States—economic, geographic, legal, cultural—it

is impossible to devise one pattern that will be applicable to all clinics. Any proposed program must take into account local conditions and modes of action. Nevertheless, it is our belief that this study has revealed some elements that are generic to effective psychiatric service for children.

If the analysis of the situation as developed in this book is correct and sufficiently comprehensive, there are five such prerequisites. In the first place, it is our main thesis that the function of a clinic must be clearly defined. This is of basic importance because answers to questions of structure, personnel, policy, services, and relationship with the public are fairly easily arrived at once the function of a clinic is fully understood. Second, it is self-evident that the clinic needs a staff adequately trained for work with children, their parents, and those who are in position to help them. In the third place, traveling clinics in particular need to adapt their services to the requirements of a non-metropolitan situation and probably give up their policy of relying on workers in other fields for the kind of treatment that only the clinic's staff itself is equipped to offer. In the fourth place, clinics should be conducted under auspices that enhance the likelihood of their being accepted and used by the public. Finally, our survey of theory and practice leads to the conclusion that clinic efforts are premature unless the community affords the resources that are frequently necessary for improving the environmental situations of the clinic's patients, and the professional public has some understanding of how to use the kind of help the clinic offers.

The first two conditions that must be fulfilled if clinic work is to be effective have been specifically discussed in the preceding chapters; the other three are implicit in much that has been said there. All, however, seem to need further examination in order that their implications for future programs shall become explicit.

THE ALTERNATIVE FUNCTIONS OF A CLINIC

It has been shown that historically and currently psychiatric clinics for children differ in their purposes. The chief objective of many of them is to reduce the number of commitments to state institutions, particularly to mental hospitals and schools for the feeble-minded. Others have as their chief aim promoting the mental health of children in general. Originally it was expected that incipient psychoses could be identified and forestalled by treatment, and later developments in mental hygiene theory led to the hope that psychoses—and crime also—could be prevented by the recognition and treatment of symptoms early in childhood. Our survey led to the conclusion, however, that psychoses can rarely be predicted in childhood, and that if they can the children are not likely to be cured by the kind of treatment available in most clinics. As to crime, it was found that the causative factors are extremely complex and that a clinic can, at best, probably be of help in only a small proportion of cases. It would seem, therefore, that those who are planning a program must ask themselves two questions about the clinic's objectives. Is the service to be set up primarily in order that those in charge of mentally defective and neurologically handicapped children shall have the benefit of the clinic's advice and help in planning for their care? Or does the clinic aim to give help to so-called problem children—those whose intelligence is at least fairly adequate and whose behavior probably represents an emotional reaction to various handicapping conditions?

These groups are not necessarily mutually exclusive. Some feeble-minded and many neurologically disabled children have emotional problems as well, and there are some cases in which a differential diagnosis of the cause of a child's behavior symptoms is very difficult. Nevertheless it is held by most clinicians that children with extreme intellectual or neurological handicaps are not good subjects for child guidance

treatment. Again, it is generally agreed that for a clinic to accept large numbers of such children as patients tends to limit its usefulness to the others, since, society's attitude being what it is, a child is in special danger of loss of social status (in his own eyes as well as in the eyes of others) if he is associated with children of these types. More important for our present question, however, is the fact that each of these general types of patients to be served entails certain consequences in staff training, kinds of service to be offered, prerequisites in community organization and understanding, perhaps even auspices under which the clinic should be conducted. Clarity in planning is obtained, therefore, only when the distinction between the two possible functions is recognized.

The consequences of confusion of function are seen most clearly in those clinics that accept mentally defective children as patients and at the same time regard only those of adequate intelligence as being amenable to treatment. This is a rather common point of view, many clinics considering it a necessary evil that their first patients should be the grossly handicapped children and looking to "community education" to bring them eventually the kind of patients they want. Clinic staffs with this mental set tend to give only perfunctory service to the great majority of their patients and to concentrate attention upon the few who are regarded as suitable subjects for psychiatric therapy. They are also likely to overlook the needs of parents and teachers in understanding and training the intellectually subnormal, for they usually have little interest in these problems and are not especially well equipped to give help with them. Schools and child placement agencies may be fairly well satisfied with the work of these clinics (for intelligence ratings may be what they chiefly want from them), but nevertheless, if the distinction between normal and abnormal is thus maintained, both these professional workers and the general public are confirmed in their

opinion of the hopelessness of feeble-mindedness and are not greatly aided in their understanding of emotional problems.

One great handicap to this proposed division of function among clinics is that the preliminary diagnosis is left to those who choose to which clinic a child is to be referred. Massachusetts attempts to surmount that difficulty by its legal requirement that all children three or more years retarded in school shall be examined by "school clinics," whose staffs are supplied by the state hospitals. In addition to the fact that those clinics do not afford the kinds of service to the feeble-minded described in Chapter XI, such a plan does not seem to be wholly satisfactory because referrals to these clinics are automatic, compulsory, and not available to the general public.

Another more obvious handicap to a division of function is found in the financial limitations of many states. It has been suggested that this difficulty might be met by combining clinics for feeble-minded and neurological cases with those which many state hospitals now maintain for adults or by leaving mental testing to the educational authorities. In both of these plans, however, case work service to parents would have to be provided if assistance of the kind we have in mind were to be assured.

If the two types of clinics cannot be maintained by a state and both functions are to be served by a single program, it must be recognized at the outset that the plan will be more complicated, the requirements in terms of staff training greater, the problem of interpretation to the community more complex, and the requests for service more numerous and time consuming. The point we are urging here is not that it is necessary for a community or a state to maintain two kinds of clinics, but that the administrators of a program should determine precisely what the clinic's functions are to be and fashion their policies in clear awareness of the needs of the

groups of children they choose to serve. If the treatment of all types of children is to be undertaken by a single clinic it is highly important that it be equipped to give and not neglect to offer to the feeble-minded and neurologically disabled children, as well as to the others, a truly psychiatric kind of service.

STAFF TRAINING AS INFLUENCED BY THE CLINIC'S FUNCTION

The training required of the various staff members under these two conceptions of a clinic's function and the ways in which well-trained staffs might be helpful to the children and those interested in their welfare have been described in considerable detail in Chapters XI and XII. There are, of course, common elements in all child psychiatry—a knowledge of the emotional needs and desires of children and their parents and ability to respond intuitively to them—that cannot be omitted from a staff's training, no matter which objective a clinic serves. But in child guidance this knowledge and capacity are utilized in a somewhat different way, particularly by the psychiatrist, and there seems little doubt that a more rigorous training in dynamic psychiatry is required of him than of a psychiatrist whose work is more medical in nature. The latter psychiatrist, working as he does chiefly with children who suffer from neurological disabilities or inadequate intelligence, has the task of judging the potentialities of these children for social adjustment. He therefore also needs the ability to elicit their fears and desires. In such a clinic, however, much of treatment rests with the social worker and the psychologist, so it is they, perhaps even more than the psychiatrist, who are in need of special training.

As conceived in modern child guidance, the role of the social worker in the clinic differs considerably from that which is usual in state-financed clinics, particularly those that oper-

ate on a traveling basis. The chief change is seen in case work with parents. Instead of being regarded primarily as sources of information about the patients, parents are now looked upon as the central persons in the case situation, since it is recognized that effective work can seldom be done with children unless their parents are desirous of the clinic's help. It may be, of course, that some children can be aided by modifications in, say, their school environment, and that some can make use of interviews with the psychiatrist even against their parents' wishes, but usually a child's fate rests with his parents, and it is to them that a clinic's help is most naturally offered.⁴ It follows, therefore, that somebody on the staff of the clinic must be available to discuss with the parents their feelings and desires about the children who come as patients and to help them work out their plans for the children's welfare, and that that person must have the kind of training which equips him to understand these problems and be of help in solving them. That task is assigned to the social worker in the modern child guidance clinic, and much of the work of history-taking and clinic management is subordinated to it.

This work with parents is looked upon as equally important in both kinds of clinics we have been considering. The parents of feebleminded or neurologically handicapped children have difficulties to face (emotional as well as practical) that are certainly no less severe than those of parents of other patients, and it cannot be assumed that these problems can be removed merely by a diagnosis of the cause of the child's disability and suggestions for his care.

There are probably some differences between the training

⁴ Were it not that there is a popular prejudice against psychiatry, it seems unlikely that we would have to argue this point. Nobody, for example, would dispute the analogous point that it is usually the parents who seek medical attention for their children, or at least that they are the ones who must assume responsibility for the carrying out of a physician's recommendations.

requirements of social workers in the two types of clinics that grow out of the nature of the children's difficulties and the means by which help can be given. It may be that the social workers in a child guidance clinic need more skill in the psychiatric aspects of their work, while the others have need of greater knowledge of community resources. If this distinction is not wholly valid, it can at least be stated with certainty that the kinds of resources to be used are somewhat different in the two clinics, and that workers with feebleminded and neurological patients need legal and medical information that is peculiar to the requirements of their job. In spite of these differences, however, the basic training needed by the social workers in the two types of clinics would seem to be very similar.

The role of the psychologist in the two clinics has also been considered in detail in preceding chapters. It seems probable that he will have the larger part to play in the work of a clinic dealing largely with the feebleminded, especially in non-metropolitan areas, for parents, teachers, recreation workers, and others will have special need of his assistance. In a child guidance clinic, on the other hand, the psychologist makes frequent use of his techniques for helping children handicapped by reading or speech disabilities. The training needs of the psychologist in these various fields are too obvious to be commented upon. It should be noted, however, that the professional equipment of the psychologist (as of other members of the staff) for work in either type of clinic should include knowledge of community resources and personnel and the ability to work with them.

ADAPTING CLINIC WORK TO A NON-METROPOLITAN SITUATION

Even with a clear conception of function and a staff specifically trained for work with children, a clinic staff faces nu-

merous difficulties in giving effective psychiatric service to children living in non-metropolitan areas. Some of these difficulties are referable to the communities in which the clinics operate, but the control of others lies within the clinics' hands. The chief problems are the following: how to make diagnostic service really useful to the persons concerned; how to provide psychiatric treatment and case work service when the clinic operates on a part-time basis; how to work with social agencies and other professional groups in a way that makes most effective use of the clinic's special knowledge. To a considerable extent these questions are interrelated, so that discussion of any one of them hinges on the answers to the others. The central point, however, is that which concerns the clinic's conception of its own job, for through this the clinic's relationship to other agencies in the community is defined.

It has been shown in Chapter XII that the contribution of a clinic to the promotion of mental health may be variously conceived. It may—and usually does—center about the treatment of the individual patient (either directly or through the improvement of his environment) or it may utilize the patients' difficulties for disclosing the weak spots in the community structure that are injurious to the mental health of many children. In either case, the clinic will work with the staffs of schools, courts, and other social agencies, and its chief source of unsatisfactory relationships lies in the tendency to tell these people how they should carry on their work. There is always much temptation to do this, for local workers favorably disposed toward a clinic seek to know not only the patients' feelings and capacities but just how they can best be served by the agency's resources. It is here that the clinic needs to keep clearly in mind its own limitations, for it is obvious that no clinic staff is equipped to tell teachers how to teach, judges to judge, social agencies how to select foster

homes, recreational opportunities, and the like. Only by holding rigorously to the lines of its special ability can a clinic give to the referring parties something which they may be able to use in the furtherance of their own work. When this principle is disregarded the clinic finds itself in the position either of taking over the work that necessarily belongs to others or of teaching them how to become therapists within a setting that is not designed for that purpose.

This danger of usurping the functions of others and arousing their resentment becomes especially great when the clinic sees its work as a means of eradicating some of the community's practices that it considers inimical to mental health. Since the objective is seldom so bluntly stated, the natural immediate reaction is often avoided, but suspicion that such was the clinic's objective seemed to account for antagonisms that were found by our survey in some centers. It would be a very emotionally secure (or perhaps very dependent) community that would entrust to a clinic the function of general remedier of evil, but it does seem possible that a clinic might be accepted—as Plant suggests—as the professional body equipped to discover danger spots, in somewhat the manner of a public health authority. If the clinic were to engage in such an undertaking it would need to pay the same respect to the individuality of a community and to give the same recognition to its right to self-determination that underlies therapeutic efforts. It has been found that communities have a great desire for local autonomy and are quick to resent the implication that they should proceed along lines which their neighboring towns have tried. They are usually proud of their past efforts and sceptical of new suggestions. If, however, a staff has a clear conception of the limits of its special abilities and a respect for the special functions of other organizations and for their desires and traditions as well, it would seem that the attempt to foster children's mental

health through an improvement in some of their environmental conditions might be favorably received.

Closely associated are the questions involved in using local workers as the continuing agents of a clinic's treatment program. Our survey showed that in most rural and semi-rural areas—and in many urban ones as well—there was a dearth of trained case workers and that the carrying out of the plans formulated by the clinic's staff frequently had to be left to people who were not only untrained for child guidance work but very much occupied with their own professional duties. School and visiting nurses and, in some sections, child welfare workers were the most frequent sources of such assistance. They were generally found to be interested in the clinics, but they themselves recognized that they were not equipped to do the kind of work that in many cases was needed. With plans for physical care, modification of school program, and foster-home placement they felt at home, but when it came to "changing parents' attitudes," as the clinics frequently advised, they were often at a loss to know how to proceed.

Many clinics did nothing about this problem, holding that their function was fulfilled when they had made their recommendations. Psychiatrists in one clinic even had the policy of putting recommendations in ideal terms although it was known that there was no immediate means of putting them into effect, the theory being that such a listing of the child's requirements was educational for the community and might stimulate it to develop the needed resources. Other clinics tried to train the local workers through case conferences, and a few allotted a small proportion of the social worker's time to supervising them. None of these methods proved very successful. They had at base the fault of assuming that the professional skill needed for child guidance can be acquired through brief and infrequent discussions of cases and that

persons with other professional commitments can devote a great deal of time to clinic work. The underlying assumption that made these obvious fallacies tenable was that child psychiatry consists chiefly of an analysis of the causes of a patient's difficulties and a listing of things to be done to overcome them. The carrying out of the recommendations was assumed to be relatively easy; once the clinic's "agents" understood the nature of a child's problem they could mobilize the community's resources for meeting it. The experience of the urban clinics in which the staffs themselves tried to work according to this theory soon disproved these assumptions. As Chapter XII showed, child guidance clinicians have come to the conclusion that there is much more to child guidance than scientific analysis of case histories, and that case work, as well as psychiatry, in such a setting is a skilled and specialized job.

A corollary of the theory that the carrying out of treatment plans can be left to local workers is that which holds that by this means the work of the clinic will be gradually reduced as agencies learn to handle problems without the clinic's help. This plan, devised by the demonstration clinics in the early days of child guidance, may have been somewhat effective in an urban setting, where the clinic was available at all times. What little evidence is available suggests, however, that even under such circumstances social agencies, courts, and schools continue to use the clinics for much the same kinds of cases over and over again and do not acquire that ability to treat most of their own cases which was one of the original aims of the early clinics.⁵ Later developments in the theory of child guidance would suggest that this would

⁵ This is the conclusion of an analysis of the work of the Washington, D.C., Child Guidance Clinic made by Aileen Burton. Unpublished thesis, Smith College School for Social Work, 1936, on file in Smith College Library. Published in abstract form in *Smith College Studies in Social Work*, Vol. VII (1936), p. 156.

almost necessarily be the case, since the work is much more specialized than was at first thought. If this has been the experience of urban clinics, it is not surprising that traveling clinics have usually been even less successful in this phase of educational work. Nor is the difficulty likely to be remedied by giving more time to conferences and consultations. Modern child guidance theory stresses the differentiation of function among agencies and the utilization of conferences for discussing each other's contributions to a case rather than for educational work. In so far as a clinic engages in education at all, then, it would seem that the objective should be the development of understanding about human behavior and about the clinic's area of service rather than about methods of treatment. Then, too, educational work should be openly carried on as such and not interjected into a situation—such as a case conference—that ostensibly has another purpose.

The implications of these discoveries for traveling clinic work would seem to necessitate a radical change in current methods. The attempt to turn nurses, teachers, child welfare agents into psychiatric social workers should probably be abandoned, and emphasis should be put instead upon the clinic's accepting these workers in their own functional capacities. Such a plan would mean that the clinic would no longer prescribe how other professional groups should carry on their work, but would give to them instead that kind of description of each patient's capacities, handicaps, and desires which is psychiatry's contribution to the understanding of human behavior.⁶ That some workers could not immediately adapt that kind of knowledge to the requirements of their own jobs would have to be accepted, though it might be considered part of the clinic's responsibility to offer assistance in that area. If,

⁶ For an interesting description of the way in which a child guidance clinic may carry on its "cooperative" work, see Harriet M. Naylor, "The Cooperative Work of a Child Guidance Clinic and a Family Agency," *Smith College Studies in Social Work*, Vol. X (1939), p. 1-36.

however, the whole community were too backward from a mental hygiene point of view, clinic work would probably have to be judged premature.

It would appear, then, that if a clinic staff confines its work to the sphere of its special competence and does not expect workers in other fields to take on tasks for which they are not trained, the clinic's relationship to the community would be defined in a way that should be very beneficial to patients. There remains, however, the question of adapting the clinic's internal procedures to the requirements of a traveling or other part-time service. Specifically, this means improving what is generally called diagnostic work and finding some means by which psychiatric and case work treatment may be afforded.

Diagnostic service usually means obtaining information about the reasons for a child's difficulties through a single interview or examination. Customarily the referring party submits a statement of the problem (which the clinic social worker sometimes supplements when the child is brought to the clinic), and the psychiatrist or psychologist or both examine the patient and perhaps discuss their findings with the person in whose hands the carrying out of recommendations is left. We have already considered the difficulties involved in the latter part of the process and suggested some ways in which improvement might be made. That changes are needed in the first part also—that, in other words, the interviews themselves might be made more helpful—was another clear finding of our study.

This is an area in which experimentation is still largely to be made. Modern theory suggests, however, that the chief function of the first interview is to ascertain the patient's or parent's conception of his problem and the probable extent of his capacity for taking help and for helping himself. The

psychiatrist's interview may, of course, have a more conventionally diagnostic purpose if the patient is feebleminded or neurologically disabled, although even such children are often helped by an opportunity to discuss their problems. Regardless of type of case, however, the social worker's objective in her interviews with parents remains the same. It is consequently of importance for traveling-clinic work that skilled case workers have found that they can often be helpful to parents in a single interview—that, as a matter of fact, this kind of opportunity to talk things over is all that certain parents want or need.

Such a conception of the function of the interview is related to the discussion in Chapter XII of the distinction between therapeutic work aimed at reforming the patient and that which attempts to free him from emotional conflict so that he can be helped to work out his own mode of adjustment. There it was pointed out that this latter aim could be maintained regardless of whether the method used in helping the patient were that of lessening environmental pressures or that of directly helping him to reduce his emotional conflict. If a clinic is confined to diagnostic work, it would seem that the environmental method would have to be largely relied upon. That the diagnostic interview itself could be made more therapeutic than is frequently the case seems, however, to be undeniable.⁷

With diagnostic work thus improved (both by setting a new objective for interviews and by adapting the "recommendations" to the needs of the referring parties), the clinic is in a position to consider how it may offer case work and psychiatric treatment also.

As to the first, a plan of having some one local person act as the stationary representative of the clinic has been tried in

⁷ For elaboration and illustration of the possibilities of the single interview, see Bertha C. Reynolds, "An Experiment in Short-Contact Interviewing," *Smith College Studies in Social Work*, Vol. III (1932), p. 1-210.

some communities. Frequently this did not prove to be successful, either because local jealousies were aroused or because the local worker was not adequately trained or not free to give her whole time to clinic work. It might be, however, that the clinic's sponsoring authorities, with or without the financial assistance of the local units, could provide their own local case work representative. The traveling-clinic staff would then correspond to the psychiatrist, psychologist, and chief social worker (or intake worker) of an urban clinic, while the local representatives would correspond to the other social workers on an urban clinic's staff.

By such an arrangement more children could be helped and to a greater extent than is now usually the case when the clinic leaves its "follow-up work" wholly in the hands of the referring agencies. It would have to be recognized, however, that a certain proportion of children can be helped, if at all, only by psychiatric treatment, and that for such children case work with parents and alterations in their other environmental situations will probably not suffice. The final question, therefore, is whether it is possible for a traveling clinic to so arrange its schedule as to permit its psychiatrist to treat a certain number of patients.

We have already noted that a few clinics have made such arrangements. The clinics of the Danvers (Massachusetts) State Hospital and the Northern New Jersey Mental Hygiene Clinics are examples. Because of the great variation in conditions that exist from state to state it is impossible to be specific about how this provision of treatment services through a traveling clinic could be accomplished generally, but a few statistics are to be noted that may be helpful here. The National Committee for Mental Hygiene reports that few cities of under 150,000 population have a full-time clinic with a staff consisting of a psychiatrist, psychologist, and two or three social workers. Such a staff, it is estimated, costs about

\$20,000 a year in salaries and treats from three to four hundred patients. Apparently such a clinic can come near to meeting the demand for service made by a population of that size, although it may be that the demand would increase greatly if the work of the clinic were well understood by the public. It would seem, therefore,—if crude arithmetical comparisons are permissible—that a traveling clinic of the same staff composition might serve four centers of about 40,000 population each through weekly visits or eight of about 20,000 through bi-weekly ones, one day per week being allotted to dictation and conference work. Less frequent visits would probably not be feasible for a clinic offering psychiatric treatment. Since, however, the majority of towns or county seats in most states have a population of less than 20,000 to 40,000, clinics established on a county basis might find treatment service more within the realm of possibility than would at first be thought.

To sum up, then, our suggestions for adapting clinic work to a community which does not have the varied resources of a metropolis and cannot support a full-time clinic are the following. (1) Change the character of diagnostic service to make the single interview more immediately helpful to patients and their parents. (2) Recognize the fact that psychiatric and case work treatment cannot and should not be carried out by people who have other professional responsibilities, and so abandon the attempt to utilize them in the capacity of local representatives of the clinic. (3) Instead of trying to give specific directions how the referring parties should carry on their work with the patients, limit the clinic's advice to the area of the clinic's own special competence—the description of the patient's needs, desires, and capacities, and how these may be utilized for his benefit. (4) Attempt to devise some plan by which at least the most needy cases can be afforded some case work and psychiatric treatment.

These suggestions for alteration in the present staffs and modes of functioning of traveling clinics are not made in the expectation that by these means the mental hygiene needs of the children of rural communities will be adequately served. Just as it seems very unlikely that the one psychiatrist in a child guidance clinic in a city of 150,000 population meets the needs of such a community, so a traveling clinic on even a county basis would probably only touch the surface of the community's needs. Adequate coverage, however, will have to wait upon the development of public demand for psychiatric service on a par with that for other forms of medical service—itself not a very effective demand at present in many rural areas. In the meantime, however, a clinic which has a well-trained staff and well-formulated conception of its function in a community can probably find a way to render service that will be a means of increasing the public's interest in mental health.

AUSPICES FOR CLINICS

We must consider next the pros and cons of the various auspices under which psychiatric service might be offered by a state. At present most state-supported mental hygiene clinics for children are adjuncts of state hospitals, while the next largest group are provided by various state departments. A very few states have experimented with clinics under public health or social welfare authorities, while some communities provide clinics in schools and in courts. The latter two types of auspices were not included in our survey, since they are largely locally financed, but as a possibility they must be considered here, since state support could presumably be afforded them.

Mental hospitals

The case for clinics under the supervision of mental hospi-

tals has many prominent supporters. Ever since the time when Meyer first envisaged mental health services embracing the whole community, it has seemed a reasonable plan that the sponsoring, supervising center of such activities should be the local mental hospital. This point of view is still widely held. For instance, a recent writer⁸ says:

It is the duty of the state hospital, as the community center of psychiatric culture, to initiate a program that will combine education and practice, beginning with the child and ending with community life as a whole.

Arguments in favor of such a plan include the availability of staff members, the already accomplished districting of the state, and the centralization of service, and it is further maintained that the state hospital psychiatrists will themselves benefit from closer knowledge of the problems of patients not acutely ill. These arguments, however, are remote from the main point—the emotional well-being of the patients—and it is around that point that discussion of the proper auspices of clinics needs to center.

In that connection some of Meyer's⁹ observations are very pertinent, even though his final conclusion is somewhat at variance with our own. He was talking in part about hospital patients, but his descriptions are doubtless equally true of those whose disorders are less severe. He said:

Our organized system for the care of mental disorder is in many respects forbidding. It throws together all kinds of diseases and shocks in that way the already sensitive patient who fears the worst for himself or herself. . . . Everything helps in making the declaration of mental disorder a painful or more or less shocking experience, and one against which the patient struggles as the culminating injustice, so that ultimately the readiness and willingness for cooperation are practically ruled out. . . .

⁸ Frank F. Tallman, "Organization of State Hospital Mental Hygiene Clinics," *Mental Hygiene*, Vol. XX (1936), p. 583.

⁹ Adolf Meyer, "The Aims of a Psychiatric Clinic," *op. cit.* (Ch. XII, n. 22), pp. 225, 228.

The clinic must become the place of help sought freely and given freely by enough patients to overcome as much as possible the usual unwillingness to accept help in matters of behavior and conduct of one's mental processes. And the clinic must be a place from which the avenues offered by the community be freely accessible.

His conclusion is that mental hospitals must be made attractive and that the hospital clinic must become a part of the organized, socialized community. In the light of the findings of our study we would raise the question whether that is a sufficiently realistic approach to the problem of meeting the mental health needs of children, and whether plans cannot be devised that will put fewer obstacles in the way of public acceptance of clinic service.

The criteria by which the auspices of clinics can be judged, however, are suggested by Meyer's statement, as well as by many of the theories of present-day child guidance. It seems self-evident that clinics for children should be conducted under auspices that have no unpleasant emotional connotation for the public, for the act of coming for psychiatric help is itself sufficiently distressing in our present culture. The clinics should be such that prospective patients and their families would have no doubt that their confidences would be respected and not possibly used to jeopardize their social or economic status. They should not denote compulsion, for few people can be helped with their emotional problems if there are penalties attached to attendance or non-attendance at a clinic. For the sake of harmony among referring agents, the clinic should perhaps not be too closely associated with any one governmental department, particularly for state-wide work.

If these criteria are accepted, serious doubt is cast upon the feasibility of using a mental hospital as the source of psychiat-

ric service to children. For about thirty years the mental hygiene movement has attempted to alter the public's attitude toward mental disease and, while progress has doubtless been made, there is certainly little evidence that many people can yet regard mental illness with equanimity, even when the patients are not closely related to themselves. It may be that the persistence of this attitude is due to the failure of most mental hospitals to alter the practices which mental hygiene as a discipline condemns, or it may be that to put mental illness on a par with physical illness is a hopeless ideal. Individual self-respect and the social order itself depend upon the belief that people have a considerable amount of rational control over their behavior, and this belief is threatened when aberrant conduct is wholly excused on the basis of emotional disorder. However that may be, it is a fact that the American public still largely regards anything savoring of mental trouble as socially disgraceful. Any kind of psychiatric service suffers from this handicap, so there is much to be said against adding to a clinic's difficulties by placing it under auspices that connote the ultimate in misfortune and hopelessness to so many people.

It has been argued that clinics, through accepting as patients people who are not psychotic and helping them to better their mental health, are furthering the hospitals' educational objectives of diminishing the public's fear of mental illness. This may be so with respect to neurotic adult patients, but when it is clinics for children that are under discussion, another factor is introduced into the argument. It has been shown in previous chapters that the movement for children's clinics under state hospital auspices was an outgrowth of the theory that approaching mental disease could be recognized and possibly forestalled in childhood. Under the impetus of that theory wider and wider categories of children were

looked upon as suitable patients for mental hygiene clinics and eventually the objective of preventing mental disease was almost lost sight of and the clinics were regarded as a means of helping any emotionally disturbed child to effect a better adjustment, regardless of whether or not he was potentially psychotic. That, in such a situation, many superintendents concluded that clinics for children are outside the scope of mental hospital work is understandable and justifiable. It has become increasingly clear that mental disease is not the only or even the chief propensity against which psychiatric help is offered to children. To regard child guidance clinics, then, as a means of reducing public fear of mental illness seems quite unwarranted, for the very suggestion that this is among their objectives connotes an attitude toward children's personality problems which tends to increase the public's intolerance of behavior that deviates from the expected.

It is difficult to see how a clinic that is closely associated in the public mind with a hospital for mental diseases can overcome the handicaps imposed by that association. They appear in the character of the referrals to the clinic, in the attitudes of parents toward making use of its services, in the purposes which the referring agents would serve by having the children examined. Our survey has shown that most of the patients of most such clinics are children who are generally regarded as extremely atypical, either because of their intellectual inadequacy or their bizarre behavior. It may well be that this situation is due largely to the referring agents' conceptions of what kind of children are fit subjects for a mental hospital, though the clinic's own conception of the services it has to offer cannot be ignored as a selective factor. All clinics find it an uphill task to demonstrate to the public with what kind of cases they can be most helpful, but the difficulty

would seem to be unnecessarily enhanced when the clinics must, in addition, convince the public that to bring a child to a mental hospital does not imply that the child suffers from an incipient mental disease.

It was further indicated by our survey that the proportion of children brought to state hospital clinics by parents on their own initiative is generally very low, nor does it usually tend to increase with the years. Lack of cooperation from parents was widely reported. Some state hospitals tried to counteract these attitudes of fear and distrust by having the clinics meet in hospitals, schools, social agency quarters, and the like, and it did appear that this was a favorable move. The most extreme example of this attempt to separate hospital and clinic in the public mind is the Worcester Child Guidance Clinic, previously described. It is a full-time, stationary clinic which was set up after very careful preparatory work, and, so far as could be learned, its clientèle and their attitudes are practically the same as those found in any urban child guidance clinic. Other clinics seem to have been successful in avoiding the mental hospital stigma in proportion to the extent of their actual separation from the institution. The possibility of doing child guidance work under state hospital auspices is furthered also by having a staff that is well trained for that work. Nevertheless, when the previously discussed inadequacies of most hospital staff members for such work are added to the handicaps that mental hospital association imposes upon the clinics' intake and possibilities of being of help, it is clear that the state hospital—for all its availability and already constituted organization—is not a hopeful source of psychiatric service to children except under very favorable conditions. It may be that with enlarged facilities it can be of use in cases of mental defect or neurological disorder, for in such cases public and scientific opinion are more nearly in accord. Even

here, however, there are obstacles of prejudice to be overcome, as well as services needed which exceed those at present offered by most mental hospitals.

Juvenile courts

The criterion of establishing clinics under auspices that have little unpleasant connotation for the public operates against those that are set up in juvenile courts as well. Here, of course, the attitudes of the families of patients would be considerably different from those just described, but that they would be more helpful is to be doubted. There has been some effort among juvenile court officials to picture their work in terms other than punishment but it is unlikely that the public has been convinced. After all, the prevention of the recurrence of legally forbidden behavior is the court's proper function, and such an aim is diametrically opposed to that of a psychiatric clinic conceived in modern terms. Court clinics are also unlikely to be able to meet the other two criteria proposed above. All too often material secured in clinical interviews is used by the judge in open court. While such a situation may but testify to the need of more adequate understanding on the part of judges, nevertheless the fear that his confidences will be used against him must almost necessarily keep many a delinquent from establishing a therapeutic relationship with the psychiatrist in a court clinic. In addition, children usually come to such clinics under compulsion, and even if their parents do not suffer from the same handicap, they are prone to see in clinics held under court auspices allies against their children rather than sources of help in regard to them.

That psychiatry has an important contribution to make to juvenile court work is not denied. Psychiatrists can be of help in determining the assets and liabilities of children who are

already court charges and in helping court workers understand something of the nature of the children's difficulties, but it seems highly dubious that the court is a good sponsoring authority for a clinic that would serve the general public. Among other reasons, the very association of courts with crime would probably be a confusing, not to say detrimental, fact to many non-delinquent children who already feel either guilty or defensive about what they or others consider their unacceptable conduct.

Schools

Schools have frequently been proposed as the most satisfactory authority under which psychiatric clinics might be held. Practically all children are known to them; they have a professional relationship that promotes a relatively objective observation of children's behavior and needs. By the close cooperation of teachers and clinic, children's progress could be observed and aided, and the school could be made a more mentally hygienic place for all pupils. In addition, even more than the state hospitals, the schools present an already established organization through which clinic work could be carried on, and even traveling clinic service seems feasible under their auspices.

The possibilities of such a program are enticing, but there are some things to be said against school clinics as well. Against the frequent proposal that teachers are in a good position to note the early signs of future mental disorder, Meyer¹⁰ has pointed out that we must "look to the school to attend to things that it can do." He continues:

I am very sceptical about the wisdom of introducing too much pathology into the work of the school. I am very much inter-

¹⁰ Adolf Meyer, in discussion of a paper, *American Journal of Orthopsychiatry*, Vol. II (1932), pp. 228, 229.

ested in promoting in every way possible an open-mindedness on the part of the teacher and not an attitude of sniffing and snooping and looking for trouble. . . . We must not expect from the school the prognostication of mental disease. We have to cultivate in the school interest in the things which are of the school and for the school and capable of raising the general spirit within which the ten per cent of needy persons may get attention without becoming marked as candidates for losing their minds.

An equally important objection from the point of view of dynamic psychiatry is the fact that the educational situation and the therapeutic situation are so different in nature that the use of the schoolroom for the treatment of problem children is considered ill advised by many psychiatrists. In the treatment situation the psychiatrist helps his patient to express his desires, socially acceptable or not as they may be. The teacher, on the other hand, is a part of the child's molding, guiding environment and must accept responsibility for carrying on that function. This is not to say that the process of education could not be improved by the understanding of human nature which psychiatry has to offer, or that a child's emotional adjustment cannot be facilitated by teachers who are alert to his needs. But to regard the teacher as a kind of assistant psychiatrist and the school situation as a means of group therapy is to lose the significance of education as an independent force in human development.

Less theoretical are some of the other objections to having psychiatric clinics conducted under educational auspices. For one thing, it is frequently difficult to avoid the association of the clinic with punishment. If this seems too extreme a statement, it is at least true that many children go to such a clinic with a sense of compulsion. Parents, too, may not want to discuss their feelings about their children with people who to them represent the school. A skilled psychiatrist may meet these attitudes in ways that permit children to accept or re-

ject help as they wish but, generally speaking, the fact that the clinic is part of the school system tends to handicap both children and parents in the use they make of it.

Other objections center around the use the school is likely to make of the clinic. Dr. F. F. Tallman,¹¹ telling of the work of the traveling clinics of a state hospital, notes that the schools tend to refer only children with serious personality and behavior problems and do not think of the clinic as a place for positive mental health. With this point Dr. H. E. Chamberlain,¹² out of long experience in a clinic in a public school system, agrees. He says:

Boards of Education have incorporated mental hygiene clinics into public school systems and both teachers and students have found them helpful. . . . Great vigilance is necessary, lest the clinic become more academic and less psychiatric, inasmuch as the tendency is to protect the existing system rather than to promote flexibility of service or to provide inconspicuous aid to the special needs of an individual child. School administrators have accepted nursing service but few have truly endorsed social service as exemplified in the visiting teacher psychiatrically trained. Many school systems still maintain attendance departments with a strong addiction to police methods of secondary rating. Unless guarded against, these mental hygiene clinics are deluged with referrals related to mental retardation, incorrigibility, or truancy—all factors that impede teaching or cast reflection upon teaching ability. School routine and the course of study are likely to be given preference over individual pupil needs or urges. Speaking generally, however, it may be stated that although the majority of teachers have had the most meager and corrupt presentation of mental hygiene concepts in their training courses, they have been . . . most receptive, albeit their security has been, at first, repeatedly challenged.

¹¹ F. F. Tallman, "Child Guidance in Schools," *Psychiatric Quarterly*, Vol. IX (1935), p. 437.

¹² H. E. Chamberlain, "A Mental Hygiene Plan Suitable for State and Full-Time Local Health Departments: a Discussion of General Concepts and Pertinent Factors," unpublished paper, presented at the annual meeting of the American Public Health Association, Western Branch, 1937.

Then, too, unless the teachers are particularly well trained in mental hygiene, there is always the likelihood that some of them will misuse the information they obtain about the children they refer to the clinic. This difficulty is inherent, of course, in the working together of school and clinic under any auspices (and can be overcome to some extent by the clinic itself) but it becomes particularly likely to appear when the clinic is a part of the school system, for under such circumstances school authorities can have much to say about how a clinic conducts its work. Two interrelated points are involved here: what kind of service the school clinic shall offer and whether teachers can assist in the treatment program. Some of the perplexities arising out of these questions have been described by Chamberlain¹³ as follows:

A clinic will have failed a school system—in fact, it will have created oftentimes a demoralizing influence—if it is satisfied to have exposed these ramifications and interrelationships of personalities between youth and adult. . . . The effectiveness of clinical procedure for a school system does not lie in the diagnoses made. In fact, it is better that diagnoses, if made, be retained for the use of the clinic staff and instead emphasis be put upon treatment in terms of a program to be followed. There is a danger, however, in such a plan. It is not that the recommended program will not be followed out. It is that it will be adhered to too protractedly, too closely or too strictly to permit variation or flexibility. Too, it is not so much the particular method of treatment that counts as it is the vision and the personality traits brought to bear on the proposed plan of treatment.
. . .

The limitations of a clinic are many. . . . The most apparent limitation then is the tendency or desire to meet all the demands put upon the clinic. If this tendency goes unscrutinized, the painstaking investigation of the individual becomes superficial or cursory. Without exception, child guidance clinics the coun-

¹³ H. E. Chamberlain, "School Clinics," *Proceedings of the First International Congress on Mental Hygiene*, Vol. II (1932), pp. 297-98, 300.

try over are tempted repeatedly, if not coerced, to sacrifice their original purpose—the intensive study and specific treatment of the individual—and enticed to swerve back into the usual stock in trade of impotent techniques. The temptation is intensified in a public school child guidance clinic. . . . Individual treatment must be delegated to others and sometimes it falls to those who relish it not, sometimes to those with a smattering of a new technique or a flair for terminology, not understanding, and naturally an effective limitation is put upon clinic endeavor.

There are, then, certain hazards to effective clinic work under school auspices that must be guarded against when a mental hygiene program is introduced into a school system. If they can be avoided, there are definite assets that the clinics under school auspices can claim. The situation is well summed up by a recent commentator¹⁴ from the educational field:

If the child guidance clinic is viewed simply as a convenient device for relieving the school of troublesome "discipline" cases, then its value is dubious. But if the teachers are really trying to understand children's behavior, if they are genuinely concerned with individual children, and if the clinic knows how to meet this need in a practical way, then affiliation directly with the schools would seem to have certain advantages that are too important to be overlooked. If this arrangement is adopted, however, care must be taken to see that the clinic continues to be an actual community enterprise, open to all agencies having to do with the welfare of children, and is adequately staffed with qualified social workers rather than with school persons of the conventional pedagogical or psychological preparation.

Social welfare departments

Other possible governmental authorities under which clinics might be conducted are the departments of social welfare and public health. The first suffers from its association in the

¹⁴ W. Carson Ryan, *Mental Health through Education*, New York, The Commonwealth Fund, 1938, p. 205.

public mind with poverty, while the latter is handicapped chiefly by its prevailing philosophy, the paucity of its present services, and the fact that mental hygiene is rarely considered within its scope. These latter objections, however, seem to be disappearing. Child welfare and public health services are expanding rapidly under the incentive of federal funds, and the socialization of medicine in general is an important current issue. With respect to the former, it is to be noted that recent (1938) federal government proposals for an enlarged public health program include mental hygiene services.

The important advantage of these auspices for child guidance services over those previously discussed lies in their direct relationship with the public. To clinics under courts or schools parents generally have access only through the medium of others, while to state hospital clinics their way is frequently barred by their own feelings about mental disease. Another advantage is to be found in the fact that the clinics' associates under public health or welfare auspices—physicians, nurses, and social workers—also serve the public in a therapeutic capacity. Accordingly, the possible confusion of function which may arise when teachers and court workers become interested in child guidance tends to be avoided.

With respect to clinics under the auspices of state departments of social welfare it has been found, however, that they often restrict their services to state institutions and agencies or at least are so engulfed by such work that they have little time for patients referred by the general public. The situation is much like that described above with regard to clinics in public schools: the clinics are not wholly free to choose either their patients or their methods of treatment but must frequently give the kind of service asked for by the various governmental departments. Doubtless this is not a necessary limitation upon clinics sponsored by departments of social welfare, particularly if the clinics are decentralized and set

up independent of other welfare activities. But in so far as clinic services are made adjuncts of public relief agencies (the other most usual method of offering mental hygiene services under welfare department auspices) they obviously are not available for general mental health work. In addition, the following limitations on this sort of consultation service have been noted:¹⁵

Many psychiatric clinics have functioned in close cooperation with community welfare agencies. The danger in this connection is not great, and yet it is not as innocuous as it might be. Welfare agencies labor against great odds—some of their own making and some over which they have little to say. Their clientele contains many permanently disabled and not amenable to any known discipline. Private agencies can afford to be experimental and liberal oftentimes, but not public agencies, to which the bulk of this type of client comes. A psychiatric clinic in this association may easily become the “dumping ground,” so to speak, by being manoeuvred into a consultation role by harassed and distraught affiliated agencies. In mental life, as in physical life, there are times and degrees beyond which the application of hygienic measures is futile, or at best is a means to belittle the guilt of indifference and neglect, public and professional.

Public health authorities

The question of establishing mental hygiene clinics under public health auspices is one that is arousing considerable interest at this time. To date few such clinics have been set up, and there are many in the profession who consider mental hygiene outside the sphere of public health. The argument centers chiefly around the concepts of prevention versus therapy. It is the long-established tradition of public health services in the United States that their function lies in promoting the preventive, not the curative, processes, the latter being considered the function of remedial medicine. Prevention is conceived as aiming “to alter conditions that lead to disease

¹⁵ H. E. Chamberlain, unpublished paper cited above.

prior to its development," while treatment "aims to remove conditions, the existence of which maintains a developed disease."¹⁶ Thus far public health activities have been largely restricted to problems of epidemiology, but it has recently been proposed by Dr. L. M. Rogers¹⁷ of the U.S. Public Health Service that a science of endemiology be developed, which will provide for the mass prevention of mental disorders through measures directed toward "individual equipment for adjustment to socialized living," and toward the "discovery and control of essential factors in the social environment." Apparently in his opinion such a conception rules out the possibility of providing clinic facilities for individual psychiatric service under public health auspices.¹⁸

Again, criteria for including any particular preventive measure in a health department's program have been listed by Dr. Allen Freeman¹⁹ to show that the child guidance function should not be assumed by public health authorities. These criteria are of particular interest in indicating current conceptions of public health services. Freeman says that a proposed program must be preventive rather than curative (health departments cannot undertake procedures that are not definitely preventive), must have a procedure that is capable of general application and effective for the whole population, must not entail unreasonable cost, and must be

¹⁶ L. M. Rogers, "The Future Outlook and Function of a Local Health Department with Reference to the Mentally Ill of a Community," *Symposium on Mental Health*, Section on Medical Sciences, American Association for the Advancement of Science, December 30, 1938.

¹⁷ *Ibid.*

¹⁸ With this point of view other public health authorities appear to be in agreement. See, for instance, the paper by Walter L. Treadway, Assistant Surgeon General, U.S. Public Health Service, "Comments on Mental Health Administration," *American Journal of Psychiatry*, Vol. XCIII (1936), p. 177-89. He suggests that the public health service collect and disseminate information on mental hygiene administration, make studies, and provide consultation service about setting up programs. Several discussants of the paper were opposed to even so much participation by governmental authorities.

¹⁹ Allen W. Freeman, "Mental Hygiene and the Health Department," *American Journal of Public Health*, Vol. XXVIII (1938), p. 241-44.

applicable by available personnel and not limited to the exceptionally gifted. On all those counts he thinks mental hygiene falls down, but he sees the possibility that a public health center might engage in preventive work through cooperation with school health departments and infant welfare centers, and provide quarters for traveling mental hygiene clinics conducted by centrally administered mental hygiene commissions.

On the other hand, a few experiments in conducting clinics under public health auspices have been tried. Freeman²⁰ reports that a program of training pediatricians and nurses for giving help to the mothers of young children has been successfully undertaken in the Eastern Health District of Baltimore, while in New York City some years ago the Milbank Fund financed a psychiatric service in the Bellevue-Yorkville Health Demonstration. A well-trained staff of psychiatrist, psychologist, and psychiatric social worker was provided, and treatment of selected cases as well as training for the public health nurses of the district was offered.²¹ It was found that the nurses tended to be over-dependent upon the psychiatrist for assistance and were not equipped to carry on much treatment (a finding that is in agreement with our survey and suggestive of the necessity of having social treatment of mental hygiene problems carried on by trained case workers), and that the demand for the clinic's service far outdistanced any possibly contemplated supply.²²

²⁰ Ibid.

²¹ Methods used in instructing the nurses are described by the psychiatrist, Elizabeth Adamson, "The Aims and Accomplishments of a Health Center Mental Hygiene Program," *American Journal of Public Health and the Nation's Health*, Vol. XXIII (1933), p. 211-16.

²² An interesting program in this field is being carried on by the Bureau of Maternal and Child Health of the New Jersey State Department of Health. Under it public health nurses are instructed in the mental hygiene aspects of their work with mothers of infants and young children and are supervised in actual practice by a trained person. For a description see Julius Levy, "An Experiment in Training Nurses to Help Mothers in Preventive Mental Hygiene," *Mental Hygiene*, Vol. XXIII (1939), p. 99-106.

It appears, then, that public health authorities are deterred from engaging in work for child guidance both by the size of the problem and by the fact that it is not clear that the work is preventive in nature. If the term prevention is used in the sense of providing against future liability to mental disease, we must agree with that point of view. If, however, prevention means providing assistance in meeting the problems of everyday life in order that individual potentialities shall be preserved, then the provision of mental hygiene services would appear to lie fully within the function of public health agencies. As Dr. Chamberlain²³ has pointed out:

Mental hygiene has been presented as though it were applicable and necessary only to those threatened by impairment or deviation from an implied imaginary norm. The application of mental hygiene should not be so construed. It should serve the bright and the robust as well, and for the optimal benefit to themselves and to others. But more pertinently it should aid the professions . . . to throw off the obsolete and the known archaic which has come down to us intact and powerfully overwhelming, even though conclusively discredited by scientific fact. If mental hygiene is to mean anything to any of us it should be conceded that it ought to lessen, by scientific and ethical means, the deleterious conflicts which jeopardize personal life, and to promote constructive cooperation in community life. Thus conceived it would be personal hygiene and public health in the broadest sense. Public health and mental hygiene are complementary. . . .

The welfare of all children is as much the responsibility of public health departments as it is the public schools'. And, moreover, it may be a greater responsibility in that health departments are not restricted to services rendered to the school's compulsory attendance requirements. As with mental hygienists, public health officials must be concerned with entire families, their association with others, and the environment in which they live. . . .

²³ H. E. Chamberlain, unpublished paper previously cited.

A clinical psychiatric service that proposes to introduce mental hygiene concepts on a health or hygienic basis in contrast to one that endeavors to determine disease processes or predisposition to such is able to assist other professional groups in a consultation role and thereby increase the permeation of such concepts much more than by the individual case treatment method. If an actual clinical service is undertaken, it is best that it be so construed as to mean that client welfare, regardless of origin or direction, be given prominence, and that the positive and constructive elements of individual life be featured. Such a service should so restrict itself that cases be accepted wherein treatment and follow-up have a teaching value for other professional groups as well as our own. . . .

The objectives of a mental hygiene plan for state or local health departments may be listed as follows:

1. Provide teaching or training facilities for health officers, nurses, teachers, and associated welfare workers.
2. Clarify mental hygiene concepts for professional groups in which the obsolete and archaic are adhered to.
3. Present from an educational or promotional viewpoint the practicability of mental hygiene concepts as applied to professional workers and laymen alike.
4. Coordinate specialized services to the extent that positive factors in client welfare are recognized to be less schematic and systematic than has been admitted heretofore.

Independent clinics or mental health auspices

The alternative to all these various auspices for mental health work is, of course, completely independent clinics or clinics under independent auspices. The programs of the mental health or mental hygiene departments of several states that have been previously described might be considered cases in point, but it has been shown that most of them do have other connections and, in addition, have been set up chiefly as demonstrations. In support of clinics independent of any particular government department it is argued that this

situation would facilitate the use of the clinics by all authorities without the possibility of interdepartmental jealousies arising and, in addition, would free clinics from the pressure of giving preference to cases from their own departments. On the other hand, the clinics might no longer be in so strategic a position to interpret mental hygiene to fellow practitioners. These, however, are chiefly administrative questions, the answers to which would vary from place to place.

With respect to the public's feeling about the matter, there seem to be two possibilities. On the one hand, it may be that more people would know about the clinics if they operated under public health or welfare auspices than if they were independently provided. Then, too, it might be easier for people to ask for help from a source with which they already had contact. This consideration would apply particularly to the economically dependent if the clinics were under social welfare auspices, but a wide extension of public health services would doubtless make clinics under such auspices well known to a large proportion of the public. On the other hand, it can be argued in defense of independent clinics that people who seek their services would tend to have a clearer conception of what kind of help they are asking for and therefore would be in a better position to use it. For it is well known that to take help with psychiatric problems is difficult at best, and it is held by some practitioners that a clinic can be most helpful when its function is clearly known.²⁴

Recently it has been suggested that a state's rural clinic program be conducted by a "mental health council" consisting of representatives of the various interested governmental departments—for instance, welfare, health, and education. Such a council would also have the function of coordinating

²⁴ See, for example, Grace Marcus, "Case Work and Mental Health," *The Family*, Vol. XIX (1938), p. 99-105, and various papers on "The Relation of Function to Process," *The Journal of Social Work Process*, Vol. I, November 1937.

the mental hygiene aspects of various activities of the departments with a view to promoting the mental health of all children, maladjusted and well adjusted alike. Before such a suggestion could profitably be put into action, however, many problems of administration and personnel would have to be explored. All in all, it is clear that there is no single answer to be given to the question of the auspices under which a state can most profitably provide psychiatric services for children. All that can be said with a fair degree of conviction is that certain governmental authorities appear to offer definite handicaps to the public's acceptance of such help.

THE COMMUNITY'S CONTRIBUTION TO CLINIC WORK

Throughout this study the relation of the community to the work of a psychiatric clinic has been stressed. It has been pointed out that a clinic cannot do effective work in a cultural atmosphere that is wholly foreign to its ways of thinking about human behavior. The supporting cultural values on which a clinic depends find specific embodiment in the community's social institutions—in its ways of behaving toward children and their problems, as well as in schools, courts, recreational facilities, and the like. Our survey showed that in many communities these values and institutions are not such as to provide a setting favorable to psychiatric work. The staffs of schools, courts, and case work agencies frequently have little knowledge of what feeble-mindedness and neurological disabilities connote in the way of expected behavior and achievement, and even less conception of children's emotional needs. Feeble-mindedness and mental disease are often considered synonymous and hopeless, the intelligence quotient is overvalued, and insufficient regard is paid to the constructive capacities latent in families and in patients themselves. It is not only that people in such communities do not agree with the assumptions of psychiatric workers about hu-

man behavior, but they have very definite assumptions of their own, which are all the more powerful for being unarticulated.

In addition to these intangible aspects of community-clinic relationships, psychiatric work in many communities is handicapped by the lack of adequate resources for carrying out treatment plans. This is so obvious a hindrance to effective clinic work as to require no further comment, though it should be noted that the best of resources in the material sense can be useless if the professional staffs are not sympathetic with children's needs.

Perhaps a case that was described to us by a worker in a remote section of a southern state will show concretely how lack of understanding of behavior motivations and lack of resources for improving a child's environment can combine to defeat a clinic's efforts. The question before the clinic was what to suggest that would help a bright, fifteen-year-old girl who had been brought up near a piggery by very young, immature, poverty-stricken parents. The girl was unpopular in school, called Piggy by her classmates, and disliked by the teachers because she performed numerous, rather amusing antics to attract attention. The school counselor felt that it was useless to talk seriously with her, so she "kidded" her instead. She shared with the local hospital psychiatrist the opinion that the girl was psychopathic. Several times the girl had been placed in the detention home for minor legal infractions (such as begging or having a bit of money that she could not account for to the satisfaction of the policeman), and the question the probation officer put before the clinic was what to do next. Vocational guidance, foster-home placement, attention to health problems seemed obvious suggestions, but the school refused to keep the girl, foster homes were said to be even less satisfactory from both the financial and the psychological point of view than the girl's own home,

and the health officer had recently antagonized all other workers by his insistence on carrying out a state law. The solution both school and probation department wanted was that she be committed until majority to an institution for the seriously delinquent.

In such a situation it seems questionable whether a clinic can carry on its work at all. Many clinics, of course, have been set up in equally disadvantageous communities on the theory that the clinic will demonstrate to the community the attitudes that should be assumed toward children and their problems. The result has frequently been that to the clinic which professes such omniscience have been sent the most maladjusted children, and in the ensuing failure of treatment the community has felt itself exonerated. Such a finding would suggest that mental hygiene education—like other kinds of adult education—cannot be imposed from above but must wait upon the development of some sense of need for it on the part of those who are to use it. In addition, it is held by many clinicians that such general educational work does not lie within the function of a clinic—that, instead, the setting up of a clinic should be a result rather than the original means of spreading knowledge about mental hygiene.

If this point of view is accepted, the question arises who should assume responsibility for what is frequently called mental hygiene education. An adequate discussion of that question is beyond the scope of this book, but a description of one recently initiated program seems pertinent, since it represents an interesting utilization of psychiatric principles in preparing a basis for effective clinic work. The program is that of the "child welfare services"²⁵ of the California Department of Social Welfare. The staff consists of a psychiatrist with long experience in child guidance work, three child

²⁵ U.S. Social Security Act, Part V, Grants to States for Maternal and Child Welfare, 1935.

welfare agents, a mental hygiene supervisor, and a stenographer-secretary. Counties have been invited to participate in the program, which is designed to provide "assistance in the perfection and extension of professional skills in relation to aspects of emotional life and the practical application thereof to undeveloped resources and actual need."²⁸ The program is based on the following principles: "that the recognition and treatment of the emotional needs of children be regarded as an integral part of any child welfare plan; that the clarification of therapeutic measures and local responsibility be made by the coordination of local effort . . . ; and that diagnostic procedures as such be interpreted discreetly and their use be properly evaluated or avoided, depending upon circumstances and objectives." The work is carried on by means of consultation about specific cases upon requests from the professional staffs of county welfare, health, and education departments, and "efforts have been concentrated on the orientation of the representatives of professional groups in reference to improved case-work practices." In addition, the psychiatrist acts as a consultant in the supervision of the county child welfare workers, conducts case and topical discussions for them and other groups, confers with representatives of allied professions, and participates in the integration of child welfare services with the other divisions of the department of social welfare.

The guiding theory underlying this educational program is that of building upon present knowledge. Mental hygiene principles are not presented in systematic form, and professional concepts and terminology are avoided. The aim throughout is to help the individual adapt his growing awareness and understanding of children's behavior to the needs of his own profession. At present no definite clinic service is con-

²⁸ H. E. Chamberlain, *Report to the Children's Bureau, U.S. Department of Labor, Regarding the Child Welfare Services Program in California*, September 1938.

templated, for it is held to be essential that understanding of the use that might be made of a clinic develop and local resources be provided before clinics are set up.

This plan of slowly building the foundations on which successful clinic work depends is too newly initiated to judge how successful it will be in overcoming the major obstacles a community may present. As judged by the findings of our study, however, it would seem thoroughly valid, both in its recognition of these handicaps and in its waiting for and facilitating the development of a sense of need on the part of the professional public instead of urging clinic services upon them. It is of interest to note that the early work of the Worcester Child Guidance Clinic was of much the same nature, although in that case some service was offered from the outset. The psychiatrist there had many personal, informal conferences with school teachers, principals, and social workers, not only about the specific children they sought to help, but about the general problems of mental hygiene in their areas of work.

The only satisfactory alternative to this method of preparing the ground for the favorable and understanding reception of a psychiatric service would seem to be that of setting up a well-equipped clinic with adequate facilities for carrying on its own treatment work and letting that work slowly speak for itself. That method has been followed successfully in certain progressive centers but it is yet to be demonstrated that even it would be satisfactory in a really backward community.

In addition to assisting psychiatric services through supporting values and institutions, communities may render more direct help to the cause of mental health and so offset the scarcity of psychiatric facilities. Schools, courts, social agencies, parents themselves are becoming increasingly interested in utilizing the principles of dynamic psychiatry in their

work with children. If this can be done in a way that preserves their original function with respect to children and does not divert it to one of individual therapy, it would seem that much of value is to be anticipated from this movement. It must be emphasized, however, that the psychotherapeutic relationship is a limited and controlled situation that is established in order to give the patient an opportunity to try to rid himself of certain handicaps to living comfortably with other human beings. To attempt to duplicate this situation in home and school is to neglect some of the most significant findings that dynamic psychiatry has to offer.

If, however, a way can be found by which the various agencies of the community can take from psychiatry its knowledge of human emotions and motivations and utilize it for the work they are set up to do, some of the puzzling problems that now handicap psychiatric work with children will be lessened and the possibility of doing effective work on a state-wide basis increased. In the first place, with such an improvement in schools, courts, social agencies, and homes, it might be expected that fewer children would need the services of a clinic. Then, too, the use which these workers would make of clinics would be more effective. They would know better which children could be helped by psychiatric study, and they could make better use of the clinics' reports. Finally, the clinics themselves could carry on their work more effectively, for the social resources on which so much of their work depends would be at hand. Our final conclusion, then, with respect to the possibility of promoting the mental health of children through state-financed psychiatric services only enlarges upon the principle with which we started—that mental hygiene to be most effective must be reflected in a way of life in the community as a whole.

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