# THE THEORY AND TECHNIQUE OF CHILD GUIDANCE

# WITH SPECIAL REFERENCE TO AUSTRALIAN CONDITIONS.

by

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# PREFACE

During recent years there has been a growing recognition of the fact that society must provide adequately for the child, and that the welfare of the society of tomorrow depends very largely upon the welfare of the child of today. Whatever may be their reasons and desired objectives, parents, educators, mental hygienists and politicians are beginning to take the child seriously, and to realize that they must plan scientifically for his developing needs.

But once attention is directed toward the scientific care and training of children, it will be seen that there are many children who for many different reasons present problems of adjustment which call for special treatment. To meet this need the Child Guidance Centre or Clinic has been developed whereby expert attention is given to the problems of the individual child.

Australia is providing reasonably well for the "normal" child (though there is considerable room for further improvements) with modern schools, health services, play grounds, clubs and children's organizations, but little has been done for the child who in any way deviates from the norm. This is not only unfair, even cruel, for the children concerned, but also it is extremely serious for society as a whole. Not only does it mean a wastage of what could be socially useful lives,

but it also will mean in the long run an increased burden on the community required to maintain the human breakdowns, the anti-social, neurotic and mal-adjusted individuals needing supervision and institutional care.

The writer has had the opportunity of studying the way the problem is being met in Great Britain, Europe, and the United States of America. Although we must guard against too readily adopting techniques and procedures in vogue in countries where conditions may be very different from those found in Australia, in the field in question much can be learned from the mistakes and achievements of those who are further ahead in the work than we are in Australia.

The aim of the present study is to examine the situation with regard to child guidance in Australia, to see what and how great is the need for this work, and to indicate how this need can be met. It is hoped that this discussion will be of interest both to all who are directly concerned with the welfare of children and to those interested in the broader aspects of mental hygiene. Child guidance is not something to be left to the professional worker alone, for it demands the intelligent co-operation of the agencies already established in the community and the enlightened support of the entire community.

CONTENTS

# CHAPTER I

## CHANGING CULTURAL PATTERNS AND THE CHILD.

### 1. The Community and the World.

Any consideration of the cultural and social changes taking place in any community or country must begin by recognizing that these changes are largely the result of changes that are taking place in the world as a whole. No community however small or remote can now live its life free from influences arising far beyond its borders. Whether we like it or not, the world is an organic unity, a fact which is further substantiated when nations attempt to deny it by means of war and conflict. The economic, social and political life of any one nation or group is ultimately a matter which it alone cannot decide; isolation in any form is no longer possible. Science has annihilated distance and made neighbours of us all, even though we may find neighbourliness an uncomfortable and difficult virtue.

Though we can readily understand that in the fields of politics and economics there is this organic relationship between our own country and that of others, it is not always so clearly recognized in the more intangible field of social and cultural relations. The patterns of life which we regard as British or Australian are not simply the result of biological, social and political conditions existing in Australia,

important as these may be; rather are they the appropriate local expression of cultural movements produced by the processes of a world social dynamics. Thus while technological development has made possible the realization of international co-operation, the struggle between rival ideologies and political systems has necessarily changed the nature of the nation itself, strengthening national barriers and making co-operation difficult and in many cases impossible.

The pattern then of a particular nation is considerably influenced by factors outside itself. War or the threat of war places the nation on a war-time economy. This means that the entire life of the nation is subordinated to the immediate needs of national defence or the tremendous task involved in the successful prosecution of a modern war. This will certainly mean that the state will assume new and far-reaching power over the private and public life of its citizens. It will mean that existing institutions and social attitudes will be subject to radical change. Private and public monies which normally would be spent on programmes of educational and social development will be diverted into channels directed towards the nation's war machine. Minority groups formerly accepted within the social field of the nation may now be considered outside it. In countries actually in the war zone there will be almost a complete restructurization of the social field, old social barriers may disappear and new ones appear, and ways of life and traditional social values will

undergo sweeping changes. In recent times we have witnessed and are still witnessing the most radical social change possible, the mass transfer of populations and the flight of hundreds of thousands of homeless refugees. That "Humanity has struck its tents, and is everywhere on the march" has taken on new and sinister meaning.

It is not intended that the general and extremely socially important question of war should be gone into here, for that would lead us too far afield. It is introduced as the most graphic illustration of the fact that social patterns within a nation are greatly influenced by the dynamics of the world situation, and consequently can only be fully understood in the light of these dynamic factors. Quite independent of war, illustrations abound of the way the world has invaded the life of the most remote and seemingly isolated communities. Fluctuations on the London or New York Stock Exchange may drastically alter the living conditions of thousands of people who may not even know what the Stock Exchange is. The newspaper, the radio and the cinema have brought the world with vivid directness into every home and community, so that a flood in the United States or a battlefront in the Balkans may seem more real to an individual than an incident occurring in his own street. Nothing can happen anywhere in the world without affecting to a greater or lesser extent every other part of the world. Consequently if we would understand the nature and direction of social changes in Australia or anywhere else, we

must see them against the dynamic background of world movements. The understanding of world social dynamics will enable us not only to understand better the immediate local situation, it will also make possible a prediction as to the general trend of future local developments. Through such prediction a greater degree of social control and planning will be made possible. Failure in social planning in the past has been due to a great extent to the failure to recognize the essential relation between local and world movements, whether in the political, economic or social field.

Because we live in a world in which new situations are constantly demanding new ways of responding, social patterns are always subject to modification, change and development. Although there may be periods when social patterns appear to be constant and stable, as in the Victorian era, this constancy and stability is only relative, for change however imperceptible is forever taking place. Hence the futility of all attempts to maintain a status quo. There are periods, however, when social changes occur with such rapidity and with such far-reaching consequences that none can be unaware of them. Such a period followed the World War of 1914-1918. The post-war changes and developments are not to be attributed entirely to the war itself, for both the war and the post-war changes were the product of economic and social forces operative in pre-war days. Nevertheless, the four years of war greatly influenced and accelerated the development of new

attitudes and ways of behaving. Throughout the world institutions and customs long held sacred and regarded as indispensable were subjected to the relentless criticism of a disillusioned humanity, which took as its theme song "Twentieth Century Blues". Hedonism and cynicism scoffed at the old sanctions and authorities. The lid was off the universe. The world was adrift, rudderless in strange waters, and for a time many were content to drift. When the history of this period through which we have just come is finally written it will have as its outstanding characteristic uncertainty. Social institutions affecting most deeply the life of everyone in the community - marriage, the family, education, religion, industry have undergone considerable change in the face of these new attitudes and ways of behaving. As these are institutions closely affecting the life of the child, we shall consider them in some detail in order to see just what these may mean to him and how adjustment to them can be made.

## 2. Marriage.

Both in oriental and western cultures pre-marital and marriage relations have been largely determined by well established traditions and mores. The conduct of young people before marriage was expected to fit into strictly ordered patterns which allowed very little intimacy, and which made a virtue of ignorance of certain essential facts of life. Although love was recognized as the motive for marriage, actual-

ly there were other important motivating factors. Marriage was generally an economic necessity not only for the woman, but also for the man under a system of domestic farming and craft-work. This economic necessity tended to create social attitudes which discouraged celibacy except for certain special groups. Thus in small communities particularly there was considerable social pressure which acted as a motive for marriage. Further, marriage was regarded as a respectable way of obtaining sexual gratification, and so sexual desire per se provided a strong incentive for marriage. Of course these and other motives were usually associated with genuine love, but as will be seen later there are indications that these motives no longer play the same role. Marriage was quite often a matter for arrangement between families (in the East this was and generally still is the accepted rule), and took place within the limits imposed by the social and economic status of those concerned. And even after marriage the pattern of living was expected to follow the traditional course. Literature abounds with graphic illustrations of the tragic consequences suffered by those who dared to defy the prevailing social attitudes. However, people in the past century did have the advantage of having accepted standards and cultural patterns by which they could order their lives with some feeling of security.

Today the situation is very different, for the Great War and the subsequent development of ideas and ways of living

have produced many changes, the consequences of which were just beginning to be understood as we became involved in a new world war. The change in attitudes towards pre-marital relations was in part a re-action against the excessive and unhealthy restrictions of the Victorian and Edwardian eras. The growing independence of women and their entrance into fields long the sacred domain of men, the revelations of psycho-analysis, particularly as capitalized by "popular" psychology and the modern realist novel, the considerable influence of the cinema, the development of contraceptive techniques, are all major factors responsible for new attitudes toward pre-marital relations. Today young people do their courting without assistance and guidance from their elders, and there is a freedom and demand for experience in social relations which would have shocked the moral sentiments of our grandparents.

Marriage is seldom an economic advantage nowadays; rather the reverse is true. Single women are now able to maintain themselves and to hold a position of respect in the community. The gratification of sexual desires can now be obtained outside of marriage with reasonable safety and often with the condonation of the particular social group. Though reliable statistics concerning pre-marital sex experience are difficult to obtain, the evidence indicates that it is undoubtedly on the increase. For example, the Fortune Quarterly Survey revealed that in the sample taken by it in the United States in reply to the question "Do you think it is right for either or

both parties to a marriage to have had previous sexual experience?" 28 per cent of the men and 17 per cent of the women voted yes.[1] It can be seen then that social pressure, economic necessity and desire for sexual gratification for its own sake, are becoming increasingly less significant as motives for marriage. Marriage now stands or falls according to the reality of the love which it is supposed to express.

However the picture is not so simple as the above brief survey might suggest. Actually a great many young people are very confused concerning this change in attitudes, they are perplexed by differences between what they have been taught and what they witness around them. The popularity of professional counselling services, newspaper columnists and pseudo-scientific sex experts of every kind, indicate very clearly that there is a wide-spread demand for information and advice on pre-marital and marital problems.[2] Unfortunately in many communities it is often very difficult for the perplexed to obtain reliable information and counselling.

### 3. The Family.

A more significant change in the general cultural pattern of special interest to us here is to be found in the

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[1] Fortune Quarterly Survey: VIII. 1937b. "Pre-marital sex-experience." Fortune, 15, 188-190.

[2] Vide Steiner, Lee R. "Where do people take their troubles?" American Journal of Orthopsychiatry, 1940, 10, 805-809.

marked transformations taking place in the structure and function of the family as a social unit. It is necessary to remember that there can be nothing peculiarly sacred or absolute about the organization of the family and family mores as we have known them in recent years in western cultures. The form and function of the family will vary at different times and in different localities according to its position in the larger social field which determines it. Thus we get differences in the family hierarchy - patriarchy, matriarchy, perhaps filiarchy. In the primitive agricultural society the family was a very important unit, in the modern authoritarian state as in the U.S.S.R. it may be of minor importance. The strength of membership character in the family will vary according to the number and strength of memberships in other social groups, for example, in the church, clubs, trade unions.

Admitting the existence of significant differences in the nature of the family in different communities, it is possible to outline the general features of the family pattern as it has been developed in countries like Australia where the British tradition of the family has been closely followed. Traditionally the family has been a closely knit unit in which the relationships were clearly defined. In agricultural and pioneer communities the father was the undisputed head of the household, making all major decisions for the family, toiling in the fields with the assistance of the mother and children as needed; the destiny of the family was

ultimately in the hands of the father.

In urban areas the pattern was very similar. The business or occupation of the father was often under the family roof or else close at hand. The mother managed the domestic affairs and took little part in life outside the home. The sons were expected to follow their father in the family occupation or to accept the profession or business chosen for them by the parents. Economic dependence generally made of the family a larger group with stronger ties than we find today. The family was expected to provide for all its members when they became unable to maintain themselves for whatever reason, as old age, sickness and the like. Difficulties of travel and economic necessity as well as family sentiment kept members of the family in fairly close association.

Now all this has altered considerably, the family has tended to become a smaller unit, and bonds once so strong have weakened. With the rapid development of means of travel and the shifting of centres of employment, family groups previously centralized have become more scattered, even to the four corners of the earth. With the provision by most modern states of invalid and old age pensions, the development of public hospitals, orphanages and institutions for those requiring protection, treatment and care, families have been freed from the responsibility of maintaining those unable to care for themselves. Structurally the family is no longer the same.

Not only has the family undergone certain structural changes, for more important dynamic changes have occurred in the relationships within the family. This can be seen when we consider the new influences which concern the interaction between members of the family. Whereas formerly the occupation of the father was generally close at hand, now, with the universal move towards increasing urbanization, it is frequently necessary for the father to travel some distance to his work. The crowded workers' trains in the early morning and late afternoon are convincing evidence of this characteristic of modern life. Moreover, where and when a man can work is for the most part decided for him by conditions beyond his control, by economic conditions, government and union regulations. The work or business of a man is now usually quite apart from his home, and frequently demands that less time be given to his domestic relations.

It is however a strange irony of circumstances that the very forces which have led to this position have also in many cases led to a tragic reversal of it. For during the last depression and since, sometimes the mother has become the bread-winner and the father the one able to devote more time to the family. This change in the ordinary roles in the family is liable to create new problems making for unsatisfactory adjustment and domestic unhappiness, a fact borne out by the experience of any social service agency. This and many other factors have taken from the father the position

of authority and leadership he once enjoyed.

The role of the woman in marriage has been affected to an even greater extent. Many time and energy consuming activities once domestic have moved from the home to outside agencies, such as bread and soap making, laundering and the making and repairing of clothes; and within the home electrical inventions of many kinds have eased tremendously the housewife's burden, and made possible the devotion of time and attention to things outside the common round of domestic drudgery. The increasing practice of birth control has made the restriction and spacing of births possible, thus relieving the woman of much anxiety and giving her an increase in freedom. The employment of women in the professions, business and industry has enabled them to be financially independent or where necessary to assist the family financially. Thus in the United States by 1930 there were 10,772,116 women in full employment, over 3,000,000 of whom were married, an increase in ten years of 60 per cent with regard to married women.[3] As in the last Great War, so this time, we are witnessing particularly in countries most seriously affected by the conflict a wide-spread movement of women into almost every possible field of occupation, and when the war is over many of these women either through economic necessity

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[3] Lord, Daniel A. What birth control is doing to the United States. The Queen's Work Inc., 1936.

or personal preference will remain in the positions which they have gained. This will have important repercussions not only on the pattern of family living, but also on the whole cultural pattern throughout the world.

The day of the large family seems to be gone. In spite of attempts by dictators to stimulate an increase in the number of children per family, there is an almost universal trend towards a decrease in the number. In England during the last ten years the birth rate has fallen 10 per cent, and during the last twenty years families of one child have increased 74 per cent.[4] Whereas in the past children grew up in the midst of the family situation as a centre of interacting personalities of brothers and sisters, today this necessary experience must be gained very often outside the family and the home. As often both father (and sometimes the mother) and children have to travel varying distances to work or school, the opportunities for the family to be home together are considerably decreased. Home becomes the place where the members of the family sleep and sometimes eat. With the building up of big cities (one third of Australia's total population lives in Sydney and Melbourne) and with the associated increase in city land prices and rates, there comes the development of the flat and apartment to take the place

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[4] Ibid.

of the self-contained private dwelling with its block of ground and garden. This means that many children are forced out into the street, public park or recreation reserve for their play. More and more public bodies, schools, clubs, play centres and other kinds of organizations are taking over the spare time formerly spent by the child in its own home. All sorts of influences such as the talkies, popular pictorials and papers, are subtly widening the child's field of interest and information and introducing him to emotional experiences which will affect his family relationships. Few adults realize how very different the experience and the intellectual and emotional content of their children's lives are from that which they recall as their's when they were young.

The change in the family situation which has called for the most comment is that produced by the universal increase in the rate of divorce. Taking the United States as one of the outstanding examples, we find that while the population increased 215.7 per cent from 1870 to 1930, the number of divorces increased 1,647.8 per cent, and that for every six marriages there is now one divorce.[5] While comparison between countries is impossible because of very great differences in marriage and divorce laws, there is evidence to

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5 Burgess, Ernest W., & Cottrell, Leonard S. Predicting success or failure in marriage. Prentice-Hall Inc., 1939, 1-2.

suggest that universally marriage contracts are not being regarded as absolute as previously, probably a desirable advance. But divorce creates as well as solves difficulties. Both of the divorced parties are forced to re-organize their pattern of living, habits, occupations, social status and interests, frequently with unhappy results. Where children are involved the situation is not a happy one for them. Prior to the divorce such children are probably living in an unhappy home torn by domestic quarrels, in which the child is naturally perplexed and not sure which side to take. Moreover he is aware that his presence is an embarrassment to the parents and very easily can feel insecure, rejected, not-belonging, feelings which the actual divorce and subsequent separation from either parent only serve to substantiate.

The family provides the child with the essential sense of security, it gives him a centre for orienting himself in the larger community. If the normal family unit is disrupted by divorce, separation or death of either parent, this centre of relative stability for the child is no longer fully operative. Thus workers in many countries have seen the broken home as a very significant causative factor in delinquency and behaviour disorders. Slawson in a study of delinquents in New York reformatories found that of 1649 delinquent boys 45 per cent came from broken homes, whereas for the total public school population of New York the percentage coming

from broken homes was only 19 per cent.[6] Studies by Burt, Healy and Bronner, and many other workers all indicate that the broken home is frequently extremely prejudicial to the healthy development and satisfactory social adjustment of any children directly concerned. Consequently, there is need for those responsible for directing the organization of society, politicians, educators, social workers and the like, to have a clear understanding of those factors likely to make for broken homes in order that the unfortunate consequences of this form of social breakdown may be prevented.

At present thousands of homes in Australia and throughout the entire world are being broken as men are called upon to leave their homes and perhaps their country in order to take an active part in the war. For some homes this will mean only a temporary break (though still not without profound psychological significance in many cases), but for others it will result in a permanent and irreparable break. Once again we will have a generation of children some of whom will not have fathers, may not have ever known a father, because their fathers went away to fight and were buried on some foreign field of war. This war, like the last will have a far-reaching effect on family life which will demand new

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6 Slawson, J. The delinquent boy. Badger Press, Boston, 1926.

adjustments to a changing family pattern. Of course individuals are constantly adapting themselves to changes in the family situation, but the war and its aftermath will make excessive demands for adjustment that many will find difficult to make.[7] That which has given both young and old alike a centre of relative constancy in an inconstant world, namely, the family as a functioning social unit, is itself subject to changes, many of which are so subtle that they may only be discernible in retrospect unless we are wise to read the signs of the times as they reveal the dynamics of social change.

### 4. Education.

Traditionally education has been the process, whether in the home, church or school, by which society sought to pass on to its children information, skills and social attitudes necessary for them in taking their place within the existing framework of society. In this connection Professor Whitehead writes in Adventures of Ideas, ". . . our doctrines of education are derived from an unbroken tradition of great thinkers and of practical examples, from the age of Plato, in the fifth century before Christ, to the end of the last century. The whole of this tradition is warped by the vicious assumption that each generation will substantially live amid

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[7] For a sketch of some of the problems caused by the evacuation of children from the cities in Great Britain, and observations on the task of adaptation and the possible consequences, see Borrowed Children: A popular account of some evacuation problems and their remedies, Mrs. St. Loe Strachey; published by the Commonwealth Fund, New York, 1940.

the conditions governing the lives of its fathers, and will transmit those conditions to mould with equal force the lives of its children. We are living in the first period of human history for which this assumption is false."[8] When the task of education was conceived as that of developing social conformity, as Whitehead suggests, the principles and methods were relatively simple and admitted of little variation or uncertainty.

It was quite natural that the Three Rs should be regarded as the fundamentals of education, and that anything else should be regarded as mere frills or as educational luxuries to be enjoyed by a select few destined by position or birth to belong to the intelligentsia. Again, it is not surprising that considering the virtual non-existence of the social sciences, education should employ the methods which society and the state had approved for centuries, that in the interests of discipline, obedience to established authority, and respectable conformity, stern measures were used. It was not simply a concealed sadism which led our parents and teacners to believe in the Biblical precept that to spare the rod was to spoil the child, though undoubtedly both parenthood and school teaching did give an easy outlet for the aggressiveness of badly adjusted adults. Most of us had very good reason for

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8 Whitehead, A. N. Adventure of ideas. Macmillan Co., 1933.

having an unholy fear of certain teachers when we were young, and can now see that all too often these were people who should never have been entrusted with the education of the children of our day. Fortunately today more attention, though still far from adequate, is given to the personality in selecting teaching personnel.

After the last war, two radically new attitudes developed in education. The liberalism and humanism which had seen in education the means of social progress throughout the world, disturbed as it was by the war, did not lose faith in education as the agent of progress; rather it was taken more seriously than ever. Education was not at fault, the remedy lay in the overhauling of curricula and teaching methods. By widening and infusing life into the content of education, democracy and progress could still be assured. Education must be regarded as education for citizenship in the democratic state. It was not fully recognized however that education may be used not only in the interests of democracy, but also for the enemy of democracy, totalitarianism of both left and right. Nevertheless, led by the prophet of liberalism, H. G. Wells, democratic educators during the 1920's and early 1930's saw themselves as engaged in a frantic race between education and the impending catastrophe, a race which catastrophe has won. We can now see that education while shaping the thought and life of a nation, at the same time expresses the social, economic and political beliefs and

attitudes of the people who make the nation, and to view education in abstraction from these things both within and beyond the nation is to be led astray by wishful thinking. The new emphasis has been for the most part a healthy one - education has been enriched by the inclusion within its philosophy of the ideas of training in citizenship and government. Moreover, it has been realized that if education is to further democracy it must not cease at the school-leaving age, for it should continue not only through the teens but make provision for adulthood as well; hence the provision of parent education, university extension lectures, workers' education associations and the like.

The most significant development has come through the rapid advance made in psychology, sociology and within the actual field of education itself, the new concept of the child-centred school; buildings, staff, curricula, techniques, developed not according to some pre-conceived adult theory, but according to the needs and interests of the growing child. Children are not to be shaped and broken to fit a particular school system or educational theory; systems and theories are to be built around the needs of children. Unfortunately, as one would expect, these new ideas have been made the excuse for all sorts of ill-conceived experimentation with children as the guinea pigs, and have produced a jargon which has been often bandied around by irresponsibles. Education by doing, creative expression, education is experience, education for

living, these are but a few of the new slogans, which like all slogans can very easily become meaningless. To label anything with a psychological tag was to explain it; a pseudo-psychology was very often a substitute for common sense and honest thinking. But when the strongest criticisms possible have been made, this new way in education remains as one of the most promising and significant social developments of modern times.

Australian education has not been as greatly influenced by these new movements as has education in some other countries. Our distance from the centres of the world's thought, Europe and America, has conferred on us a certain degree of intellectual isolation. A highly centralized system of education, while maintaining educational standards often difficult in a decentralized system as at present in the United States, tends to the development of a dull uniformity in which really creative experiment and progress are not encouraged. Thus some of the best advances in Australian education have come outside the state school system in schools privately controlled, for example, Geelong Grammar School. Moreover, the notoriously inadequate government expenditure on its schools, and the strange lack of public interest in the education of the nation's children, to say the least have not been in the interest of progressive education, facts which the visitors to the New Education Fellowship Conference in Australia in 1937 were quick to comment on.

Although the Australian school system may have been unduly conservative and not sufficiently responsive to reforms

accepted almost as axiomatic overseas, nevertheless in the last ten to twenty years a remarkable change has occurred within the field of Australian education. Not only has there been a revision of curricula and teaching methods in the direction of a more progressive education appropriate to Australian conditions (to give an example, the development of young farmers' clubs in country schools), there has also been a change in the spirit and attitude of both teachers and students.

Unfortunately these changes are not always appreciated by parents and others who complain "that schools are not what they were when we were young," adults who still think of education in terms of the three Rs and the strap or cane. One difficulty which almost every teacher and principal must meet is the disparity between the methods of discipline and the ideas and ideology accepted in the school, and the discipline and attitudes accepted by the child in the home. Here we have a real source of confusion and difficulty for both the adult and the child in a situation which is of first importance for the adjustment of individuals in a changing cultural pattern. An unsympathetic or misunderstanding parent will make the task of the teacher additionally difficult, and will subject the child to a conflict of loyalties and authorities which may well result in an undesirable solution in terms of neurotic behavior.

The fault does not always lie with the parent. It is

quite possible for the enthusiatic teacher to be so possessed with the importance of his or her job and with the idea of new techniques and theories, that a sense of perspective is lost. Sometimes the essential nature of the child's membership in other social groups such as the home and family is not properly recognized. Education is not and should not try to be a substitute for the authority and experience within the family group; rather it should endeavour to enrich the quality of these and other natural social experiences. This constitutes a real problem for the educator who has a thorough understanding of his work in relation to the whole cultural pattern of the community.

With the acceptance, in principle at least, in Australia of the idea of school as being centred around the needs of the child as a growing individual and not simply as a passive recipient of educational pills, there has come the recognition of the fact that not all children are capable of profiting by the same educational methods. Obviously, the blind, deaf and dumb, and physically crippled cannot fit into the normal school programme, hence provision has been made for them. But the same provision has not been made for those who are considered as mentally backward or defective. While society as a whole has made it almost impossible for the mental defective to find a place within its economic and social framework, the school system has done little to provide for him in an appropriate manner. In 1932, Dr. P. M. Bachelard made

the very conservative estimate that in Victoria there were over 8000 mentally retarded or defective children under sixteen years of age, of whom twenty per cent would require institutional care, and the other eighty per cent training in special schools. Actually only three such schools catering to 175 children existed in Melbourne.[9]

In addition to the problem of the child sufficiently retarded to be considered mentally defective, there is the problem of the child who is retarded to the extent that special teaching is required apart from the ordinary graded class. In Victoria an inadequate attempt to meet this situation has been made in the establishing of the 'opportunity class'. Not only do these classes tend to become dumping grounds for various types of problems which cannot always be satisfactorily dealt with under existing conditions, there are also too few of them. After investigating the problem of the retarded child in Australia and educational provision for him, Dr. E. G. Malherbe concluded: "Probably not more than 700 or 800 retarded children in Australia are receiving some sort of special attention, while the statistics suggest that about 40,000 definitely need it."[10] What happens to the 32,000

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[9] Bachelard, P. M. The education of the retarded child. Melbourne University Press, 1934.

[10] Malherbe, E. G. Retardation, its causes and prevention. Proceedings of the New Education Fellowship Conference, Australia, 1937, published as Education for Complete Living, Australian Council for Educational Research, 1938.

retarded children who receive no special attention? Some drop out of the school system; the great majority unable to cope with the regular school programme lead a miserable existence as a source of trouble to the teacher and a source of amusement to their fellow, eventually leaving school to become permanent social misfits. This of course is a serious situation which society cannot afford to allow continue.

In the last century prior to the tremendous development in industrialism and urbanization, when life was more simple, retarded and defective persons could more easily find simple employment under conditions not demanding great initiative or capacity for adjustment. Living in the small town or on the farm was relatively simple and safe. Today, the backward and untrained cannot hope to compete in the overcrowded labour market. Life in the big city is full of hazards for the seriously retarded, and in turn he becomes something of a hazard for the life of the community. Though many of the estimates made in the press and elsewhere as to the percentage of defectives in the delinquent and criminal groups may be exaggerated, studies in Australia and in other countries indicate that defectives do contribute more than their share to the anti-social groups. M. T. Woods in her study, "Juvenile Delinquency", reported that of 1061 boys passing through the Victorian Children's Courts in six years, 12.5 per cent had an I. Q. below 70, whereas according to the curve of normal distribution of I. Q. one would find only about 1 - 3 per cent

of boys falling in this I. Q. class.[11] Modern society in its economic and educational organization has revealed the mentally retarded and defective not only as an individual problem, but also as a social one. It is not justifiable to think about it in terms of the last century or to refuse to think about it at all, for with adequate training and care many of these children can become self-supporting, useful citizens; but without this necessary provision for them, many of them will swell the ranks of anti-social, dependent and unhappy residents of state maintained institutions, a burden on the community.

Education today is not only faced with the problem of the retarded and defective and those children presenting behaviour disorders of various kinds, which is to some extent increased by different trends in modern life, and which is now becoming a real problem because educators are growing increasingly more sensitive to it, but education is also faced with serious difficulties of a much more fundamental kind. Formerly, education was carried on in three distinct phases by three clearly defined agencies, the home, the church and the school. But nowadays the home may not count for very much in many cases, the church perhaps not at all, and instead of these influences we have a whole battery of new influences,

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[11] Woods, M. T. Juvenile delinquency. Melbourne University Press, 1937.

the exact character and value of which it is difficult to determine. The school has to compete for the interest of the child with all sorts of subtle and attractive commercial enterprises, frequently inimical to the ends of education. Speaking of these influences in the 1939 John Smyth Memorial Lecture, Mr. J. D. G. Medley made the following comment: "The world has never been so full of instruments of information and persuasion as it is today, never so full of subtle and organized lying, never so full of external stimulations of the basest and most valueless kind. From his earliest days the child is being told on every hand how to be successful, how to be beautiful, how to be popular, how to be athletic, how, in fact, to be anything and everything but a lover of truth, freedom and justice. He is encouraged by his environment to become a purposeless addict to films, wireless inanities, detective stories, and the press; he is liable to feel subnormal and incomplete if cut off from them for any length of time; and abjectly dependent on incessant stimulation from without, will develop into the easiest of victims for the first propagandist that passes his way."[12] This is only one side of the picture, for many of the things mentioned by Medley are undoubtedly of positive value also, but the fact remains that the agents of education for good or ill are now many of them outside the control of the school, church and home. Education must work

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[12] Medley, J. D. G. Education for uncertainty. Australian Education Studies, (Second Series). Melbourne University Press, 1940, p. 24.

within this new and complicated pattern of life for the child.

Unfortunately the educator cannot meet the situation with very much confidence. The new insights of the biological and social sciences have led to a good deal of confusion in education as to means and ends, techniques and values. A world in which long-established political and economic systems are engaged in a death struggle with powerful, devastatingly powerful, new forces, is one which all too easily can produce a feeling of insecurity and uncertainty even among those to whom the rising generation must look for leadership and guidance. Education has to educate for uncertainty where before there was certainty, and it would seem as if so far it has failed. Medley in the lecture from which we have quoted draws the sad conclusion that "You <u>can</u> educate <u>for</u> uncertainty - we are faced with that today whatever our theories may be - but you cannot educate <u>in</u> uncertainty - in uncertainty of your true ends - without disappointment and confusion. That a large part of the world has been educated in uncertainty is the root cause of the troubles with which we are beset."[13]

If in recent years education has been subject to changes in methods, contents and principles, which have demanded adjustments on the part of parents, school staffs and pupils,

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13 <u>Ibid</u>., p. 14. Second and third italics are mine.

adjustments which they have not been able to make satisfactorily and consequently have been productive of confusion and uncertainty, then we can be sure that the tremendous demands which the future is going to make will necessitate even greater efforts at adjustment if an even more serious confusion is to be avoided. Where there is unsatisfactory adjustment within a community, we can expect that one result at least will be an increase in the number of children who will be maladjusted, requiring expert assistance from the community which has very largely been responsible for their difficulties.

### 5. Religion.

As has already been suggested, in past years one of the most important formative influences in the life of the child and the community as a whole has been the institutionalized religion of the church. For centuries in western cultures the church as the social field determined by the Christian conception of God has exercised considerable influence not only upon those having membership in it, but also upon the culture pattern as a whole. The theology, structure and function of the church have varied at different periods and in different countries in response to changes occurring in the wider social field of which the church was a part. These differences are so great even within one particular church denomination from time to time and from one community to another, that it is very dangerous to make any generalizations concerning the church as a whole. However, it would be generally agreed that

the church has exerted a considerable influence on, and at times actually dominated, practically every aspect of life, personal ideals and beliefs, education, politics, business, international relations. The church superintended all the major events in the individual's life, birth, marriage and death. The church was necessary for the baptising of a baby and the blessing of a battleship. The clergy held a high place in the political and social life of the community, and irrespective of personal character and ability exercised a good deal of power over the lives of everyone in the community, being given respect and obedience in virtue of their office.

It would be possible to write the history, not only of individuals, but countries, in terms of their relation to the church of their place and time. The church for centuries represented a social field in which individuals had membership without serious conflict with membership in other social fields. But from the Reformation on this situation gradually and with increasing extent changed, until now the church is but one of many social fields in which the individual may have membership, such as the state, trade union or employers association, scientific and vocational groups, recreational and sporting clubs, and all the various other organizations which invite membership and confer privileges and responsibilities upon their members. The church has lost the monopoly of an individual's interest that for so long it enjoyed, and now it must compete with countless organizations, some of which

have taken over activities previously considered the peculiar function of the church. For example, an increasing number of people are married without the assistance of the church, and when they die are buried without religious ceremony. The clergy have lost much of the prestige which was their's in former times, and with the possible exception of the Roman Catholic Church, no longer have authority over the lives of church members. Church leaders may talk of the possibilities of a "revival", but it is extremely unlikely that any such revival would be comparable in its intensity and effect to the revivals of the past, such as that associated with the name of John Wesley in the eighteenth century. After discussing this wane in the influence of the church, Professor J. F. Brown in his work, "Psychology and the Social Order", comes to the conclusion that "It is more than probable that religion is a dying issue for modern man", and that "The time draws near when organized religion will probably disappear as an important social force".[14]

Although these predictions may prove incorrect, there is very good evidence that even church leaders themselves realize that their position is becoming increasingly difficult. Thus in the Pastoral Address of the Methodist Church of Victoria and Tasmania, 1940, we find the statement that "Religion is at a discount. Statistics tell us that of the 50,000,000 in

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[14] Brown, J. F. Psychology and the social order. McGraw-Hill Book Company, 1936, 150-158.

England 22,000,000 ignore the church. In America, of her 130,000,000 just half ignore the church. Of our 7,000,000 in Australia, just half declare themselves as quite indifferent to religion. Of the general public, only one out of ten go to church. Such figures speak for themselves."[15] An analysis of the last Australian census returns clearly indicates that this drop in church membership has steadily increased over the last twenty five years, and in its extent is significant of a relatively modern trend in social attitudes. Whether this decline in interest in organized religion is a good or bad thing from the point of morals does not concern us in this study. We are interested, not in passing judgments, but in the examination of meanings. Accepting the fact of this decline of interest in the church, what does this mean for individuals and the community?

Probably the most important need in individuals that the church has met is their need for security, their need for belonging somewhere irrespective of who they might be, their need to be considered important, however unimportant they may be in real life. In commenting on this fact, J. S. Plant in his illuminating study, "Personality and the Cultural Pattern," states that "In the religious concepts individuals largely meet their security needs . . . Note that God cares for

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15 Minutes of the thirty-ninth annual conference, Methodist Church of Australasia, Victoria and Tasmania Conference, 1940, p. 45.

people (as do parents) because of who they are - regardless of riches, social position, or I. Q. Here then is a haven of safety - a place where there is position simply because persons are persons - a more permanent carrying on of those things the Family has given."[16] This is one reason why in the past religion found its strongest support amongst the under-privileged and insecure groups in the community, people who had been judged by society to be of little value, and who had been denied any real sense of security, honour and prestige. In strengthening the ego of such people the church undoubtedly supplied a socially valuable service. Similarly, the church has attracted those with feelings of personal inadequacy and insecurity, the adolescent and the adult neurotic, and in so far as it has provided such with a socially satisfactory solution to their problems, the church has been a significant factor in the stability of a community. The church has also helped in the maintaining of social stability in that it has usually identified itself with the more conservative elements in the community life, and whether this has been in best interests of social progress or not, it has strengthened the sense of security of at least that section of the community dependent on the status quo, the section now represented by the great middle class.

But today more and more people are seeking security outside

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16 Plant, J. S. Personality and the culture pattern. Commonwealth Fund, New York, 1937, p. 384.

the church. The under-privileged are turning to saviours who promise them the economic security which the church has been unable to give them. The maladjusted are turning to religious sects outside the orthodox churches, or to psychologists and psychiatrists. The upper and middle classes are seeking their security in the power of the nation's fighting forces. The question is how satisfying can these sources of security be? Already the indications are that they cannot in themselves meet the eternal quest of individuals and societies for real security in which to live.

A second value that the church has had is that it has helped maintain the family as a social unit. There is obviously a close relation between the family and religion, and that the strength of one has depended to some extent on the strength of the other. The church has always emphasised domestic and family virtues, and regarded any attack on the institutions of marriage and the family as an attack on religion itself. Thus the general opposition of the churches to changes in these institutions in the U.S.S.R. Religious concepts are very largely derived from family relationships: God is the Father, Jesus Christ the Son, Mary the Holy Mother; and the major events in the life of the family are given religious significance, marriage, the successful delivery of the child at birth, the naming of the child, and death. As we have already seen the family plays an essential part in the development of the child, and is a centre of orientation for both children and adults.

Consequently in strengthening the foundations of the family and giving it divine sanction, the church has helped maintain something which we are realizing more than ever to be necessary for the life of individuals and the community. Though the changes and loss of position of both the family and the church are the result of changes in the entire social field, it would seem as if the decline in power of the church has contributed to a weakening in the power of the family, and vice versa.

A third value of the church has been that it has provided a system of ethics and a way of life, giving the ego rational determinants for behaviour and the super-ego socially acceptable content. In the authoritarian churches this was found in the pronouncements of the church and in the various services; in other churches in the infallibility of the Bible or the teaching of Jesus, or in what was called the guidance of the Holy Spirit. Religion provided a scale of reference by which one could determine one's conduct. God or the Church was regarded very much as a kind of universal policeman and judge, a socially useful idea. The church and Sunday school assisted the family and other agencies in the moral education of the young. However, today many reject the authority of both the church and the Bible, doubt the relevance or character of the Christian ethic, and prefer the dictates of reason to the mystical guidance of the Spirit. Children are no longer sent to Sunday school as once was the regular custom, and many of them are growing up without any religious training whatso-

ever. Moreover, those who do go to church or Sunday school often recognize lack of agreement between what is taught in the home or school and what is taught in the Sunday school. They tend to be critical both of the methods and content of the religious teaching, and the great body of them break their religious connections by the time that they reach high-school age. In Australia, the attractions of the outdoors and sport made possible by the climatic conditions represent competition extremely difficult for religion to seriously challenge. There are so many things which seem more attractive to both the child and the adult.

It can be seen then, that the institutional religion represented by the church which traditionally has played an important role in determining the cultural pattern, by providing security and meaning in life for a large proportion of the community, by supporting the family and other social agencies, and by perpetuating moral standards considered desirable, by training the young and guiding adults, no longer supplies these values for an increasing number in the community. One will evaluate this development according to one's particular view of life in general. However, if it is agreed that the church has survived and still survives because it has met certain needs in the life of individuals and the social group, then in so far as it ceases to do this adequate substitutes must be developed; and many of the present substitutes are not adequate or satisfactory. In the meantime, we have a

disconcerting amount of confusion, uncertainty, insecurity, and breakdown in social organization.

### 6. Industry.

The last major factor in the general social field determining the culture pattern of the community which we will discuss here is industry. By industry is meant the conditions and manner of people's work. Whether one agrees with the Marxist or not that this is the basic thing on which all else depends, enough has already been said to indicate that there exists a very close relation between industry and other factors in the social field, marriage, the family, education, religion. What then are some of the features of industry which are relevant to this study?

In recent years there has been a rapid extension of the manufacturing industries and of the mechanization of all forms of industry. This is a universal phenomenon evident in Australia as elsewhere. Thus while in the year 1921-2 there were 378,540 people employed in industry in the narrower sense of the term, by 1936-7 the number had increased to 523,824. In 1922, the number of persons engaged in industrial occupations in Australia exceeded those in all the primary industries by 22 per cent; ten years later this excess had increased to 32 per cent.[17] This was not due simply to an increased

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[17] Official year book of the Commonwealth of Australia. No. 31, 1938, p. 352.

emphasis on the secondary industries, but was the result of the application of new techniques to agriculture and the development of modern farm machinery requiring less man-power. The development of a highly mechanized industry has led to two important social trends - increasing urbanization and the progressive depersonalization of economic institutions and human relationships.

The extent of urbanization in Australia can be easily demonstrated by a few relevant statistics. The distribution of population as shown by the 1921 census compared with that of the 1933 census is as follows:

| | 1921 | 1933 |
|---|---|---|
| Urban | | |
| Metropolitan | 43.01 | 46.87 |
| Provincial | 19.09 | 16.97 |
| Rural | 37.35 | 35.91 |
| Migratory | 0.55 | 0.25 |

Thus even for such a short and recent period as that given above, a shift of the population away from rural and provincial districts is revealed.[18] This is particularly significant when one considers not only the distribution but also the density of the population. Australia is the most sparsely populated of the civilized countries of the world, having a density of only 2.33 persons to the square mile. The United States with practically the same area has a density of 41.1 persons to the square mile.

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[18] Ibid., p. 321.

Statistics however must be translated into terms of people and the meanings which changes indicated by statistics have for them. For those who are part of the movement from the country to the city adaptation and adjustment to new ways of living will be necessary. This adjustment will be made difficult by the uncertainty of employment and the higher living costs usually associated with life in the big city. For the unskilled farm labourer forced to the city in his search for employment, and for the young country bred boy or girl of teen age seeking the more attractive city life, there are many hazards in the way of successful adjustment. In the absence of data concerning the meaning of this situation both for the individuals concerned and for society as a whole, it is not possible to do more than to suggest the need for recognizing the existence of this problem bound up with increasing urbanization.

The building up of large cities to meet the needs of large scale industries and the concentration of population are developments with both advantages and disadvantages. The big city can provide living comforts and cultural institutions quite impossible in a rural community or small provincial town. But the price society pays for these benefits is a heavy one. Life in the city is much more intense than in the country, the struggle for existence much more keen. Anyone who has lived in a big city knows that even the simple routine matters of everyday life, boarding a train or bus, getting a meal in a

restaurant, crossing a street or walking along a crowded sidewalk, illustrate the idea of the survival of the fittest as well as life in any primitive jungle.

Reference has already been made to some of the features of city life affecting the nature of the family and its members. The increase in land values and rental rates have led to the increase of tenements and flats. Thus for the period 1921-33, while private houses in metropolitan areas in Australia increased by 48 per cent, tenements and flats increased by 122 per cent, as compared with an increase in the population of 32.9 per cent and of 39.5 per cent in the number of married persons in the same area during the same period.[19] This is probably symptomatic of a changing attitude towards the function of the home as well as a contributory cause for this changing attitude.

The congestion of population in the urban community exposes both children and adults to influences of which otherwise they may be unaware. Children are forced out into the streets or parks for their play, and early become regular patrons of the cinema. Many adults are denied the privacy desirable for satisfactory domestic life and necessary in most societies for the maintenance of self-respect. J. S. Plant considers that congestion in the urban area contributes

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[19] Ibid., p. 359.

considerably in children and adults to a lack of self-sufficiency, to the destruction of illusions or ideals socially valuable; it is responsible very frequently for an introduction to sex which is devoid of attitudes of respect and love; and it creates "mental strain" expressing itself in negativism and irritability, due to the need of the ego to be on constant guard against the preying eyes and intrusions of those in the immediate environment, from which there is little chance of escape.[20] Studies conducted both overseas and in Australia suggest that there is some direct relation between the incidence of delinquency and crime and living conditions in congested urban areas.[21] Certainly living in densely populated urban areas presents definite problems of adjustment not found in more favourable environments.

A further important feature of urbanization is the growth of what can be called "mob" attitudes and ways of behaving. This has been very well described by Dr. Robert Waelder, psychoanalyst and editor of "Imago". "By the mob", he says, "we mean not merely the transitory mass formations of people without strong convictions who easily fall victims to slogans and demagoguery; we mean as well the attitude of the spoiled

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20 Plant, J. S. op. cit. (n. 15), 213-228.

21 Shaw, Clifford, and Others. Delinquency areas. Chicago University Press, 1929.
Barnett, F. Oswald. The making of a criminal. Stuart Taylor, Melbourne, 1940.

child of our wealthy civilization who no longer thinks of the community as something which may legitimately ask for sacrifices, but rather as something which must provide him continuously with gratifications of his desires. The slogan of Rome's Metropolitan mob 'Bread and Circusses' is the classical expression of mob psychology for all times."[22] How to substitute a sense of community responsibility and civic pride in place of the irresponsibility and indifference of the mob remains a serious problem for those interested in maintaining the integrity of the modern democratic state.

The second important social trend associated with the development of a highly mechanized industry and increasing urbanization which will be discussed here is the progressive depersonalization of economic institutions and human relationships. This enters into every aspect of life. Men and women in industry cease to be persons, and become hands, so many units of labour, to be employed or dismissed according to market conditions and other factors usually quite out of their control. Where and how they will work, what they will make and what will be done with the fruits of their labours, are matters concerning which the great mass of workers have very limited understanding, little responsibility, and often no control.

Ideally, work represents an integration of an individual's

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[22] Waelder, Robert. "Democracy and the scientific spirit." American Journal of Orthopsychiatry, 1940, 10, 453.

ideas, feelings and motor skills. But under modern industrial conditions, work becomes dissociated from the rest of an individual's life so that this integration becomes difficult, if not impossible. For some workers this may lead to excessive day-dreaming during the hours of work, a weakening of morale and incentive, decreased efficiency. Undoubtedly this feature of working conditions is in part responsible for the apparent increase in psycho-somatic disorders amongst workers.[23] Naturally when the worker cannot satisfactorily express his ideas and feelings in his work, and when it does not permit the development of individual prestige and the sense of achievement, substitutes must be found elsewhere. In some cases at least the finding of appropriate, healthy substitutes is not easy.

The most undesirable result of modern industrialism is the increasing insecurity of the worker, and the creation of an unemployed class, many members of it becoming virtually unemployable. So rapid and unpredictable are the changes and fluctuations within industry, that no workman can feel really secure. A new invention, the loss of a particular market for goods being produced, re-organization in a factory, may immediately throw a man into what may be permanent unemployment.

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[23] Books dealing with mental hygiene problems in industry and business are:
Anderson, V. V. Psychiatry in Industry. New York: Harper, 1929.
Fisher, V. E., and Hanna, J. V. The dissatisfied worker. New York: Macmillan, 1931.
Mayo, Elton. Human problems of an industrial civilization. Macmillan, 1933.

This insecurity casts its shadow over the boy leaving school and seeking a job. Youth has no guarantee that it can find employment in the fields for which it has been trained, or that such employment has any future.

Depersonalization affects the unemployed even more than those engaged in the vast, mechanistic, industrial system. The unemployed man becomes a statistical unit dependent on the state or charity for the means of living. But behind unemployment statistics lie the stories of frustrated, bewildered people. The possession of a job is a sign that one is an independent, worthy and socially acceptable person; the loss of it marks one as a failure, an unwanted burden on the community which regards success in business as a major virtue. Commenting on the seriousness of the process of depersonalization caused by modern economic conditions, Dr. Harmon S. Ephron writes: "The process gives rise to an appallingly pathological society, characterized by such ills as debt servitude and dispossession of farmers, terror of permanent unemployment, and the shrinking of opportunities for youth. These defects constitute a primary attack on the basic safety of the individual whether or not he is predisposed to neurosis, and regardless of his status."[24]

The depersonalizing of human relationships is not confined

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[24] Ephron, Harmon S. "Mental hygiene in social reconstruction." American Journal of Orthopsychiatry, 1940, 10, 458.

to industry, for it is characteristic of all departments of modern life, especially in cities. Much of our entertainment comes through the impersonal media of the radio and cinema. The department and chain stores and the facilities which they supply have eliminated many of the inter-personal relationships in buying and selling. One may live in an apartment without ever knowing even the name of the owner. Even the relationships within the family tend to become more impersonal owing to conditions of work, sport and recreation, which often separate members of the family and take them more and more out of the home. Most of the old ways of living are undergoing rapid and extensive change, according to which individuals must make constant re-adjustment.

Thus it can be seen that the evolution of industry, with its tendency to promote increasing urbanization and the de-personalization of social relationships, creates situations for individuals and society which are productive of insecurity, uncertainty, frustration, and demand a capacity for adaptation which for many individuals and for some societies at least will be too great.

### 7. The Child and Change.

The foregoing discussion has been concerned with the nature of major social changes occurring in the modern world. It was seen that these changes are universal in their extent, and that the particular incidence of change in any given community is to be understood not simply in terms of local con-

ditions, but according to the dynamics of the wider social field, the world. An attempt was made to indicate the meaning for individuals and society of some of the changes taking place in certain of the more important aspects of the total cultural pattern, namely, marriage, the family, education, religion, industry. Although change is an ever-present phenomenon, the rapid rate and the wide extent of recent changes have been productive of much confusion, uncertainty, and sense of insecurity on the part of both individuals and the communities to which they belong.

These changes are extremely significant for the child. Some of the changes which have been discussed directly affect children even more seriously than adults. Thus an alteration in the divorce laws will have far-reaching consequences for children if such alteration makes possible the divorce of their parents. Children in a family in which the mother has to work in a factory because of the inability of the father to obtain employment, naturally will be affected by the change in the parental roles. New teaching methods and revised school curricula will have direct bearing on the behaviour of the pupils, both in and out of school. Whether or not children are forced to go to Sunday school will be of significance for their moral development. A drastic drop in the economic status of the family, due perhaps to some distant market fluctuations, may influence profoundly the attitudes, ambitions, and entire future of the children.

If events and situations such as those we have been discussing are really disturbing for the child, they may precipitate immediate behaviour difficulties. The child who is separated from the father may develop extremely aggressive behaviour against the mother. An event of little consequence to an adult may produce all sorts of fears and anxieties in a child. Sometimes the nature of an event may be such that it will have a traumatic effect, the influence of which may last long after the event is forgotten. However important these experiences apparently may be in leading to particular behaviour difficulties, they should be regarded merely as precipitating factors in the total causal picture. More important is the question of why a certain experience precipitates the behaviour difficulty. Why does failure in school result in delinquency or neurotic behaviour in one child, lead another to greater scholastic effort, and leave a third unconcerned? How the child reacts within the dynamic configuration of any given situation depends on what the child is as a growing, adjusting, developing personality. The development of personality depends in no small measure on the changes in, and the character of, what we have called the total cultural pattern. In order then to understand the full significance for the child of changing cultural patterns, a brief account of the genesis of personality is necessary.

Without going into the highly controversial subject of the definition of personality, we shall define it simply as

the pattern or configuration of traits in an individual, which are so organized as to confer upon him individuality. This configuration includes all the physical characteristics as well as those usually referred to as mental. There is no need to raise the sterile heredity-environment and body-mind arguments. For all practical purposes there can be no heredity without environment; no mind without body. From the time of conception till death, heredity and environment, body and mind, function in an inseparable organic unity.

In its origin a particular personality represents a crystallization out of the total pattern of human nature surrounding it. "The emergence is definitely an individuation from the total pattern, because the circumstance responsible for the appearance of the personality is the constant dynamic relation existing between the individual and the group."[25] This dynamic relationship is at first between the baby and its mother, but rapidly extends its limits with the process of maturation. Personality therefore is the result of the dynamics of the situation in which the growing human organism finds itself, a product of the reactions of the organism to strains and stresses, frustrations and satisfactions.

Dr. J. F. Brown has convincingly demonstrated that the

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[25] Wheeler, R. H. The individual and the group: an application of eight organismic laws. Readings in Psychology. Thomas Y. Crowell, New York, 1930, 15.

character of the different personality traits is largely, if not entirely, determined by the character of the different groups or social regions to which an individual belongs.[26] An individual's attitudes toward life in all its various aspects depend on the nature of the groups of which he is a member, his family, school, church, economic class, and so on. Changes in the character of the groups of which an individual is a member will bring changes in the individual. The same person may act quite differently in different social situations. Mr. Smith as a member of the business group may be a very different person from Mr. Smith the family man. Sometimes there may be conflict between the demands of membership in different groups; for example an individual may be torn between the demands of the state and those of his trade union.

This is all of first importance for understanding the personality and behaviour of the child as well as of the adult. It means that to understand the behaviour of the child, whether it be normal or what is commonly called abnormal behaviour, it is necessary to understand the meaning for him of the social field of which he is part, to understand the effect of his membership in a certain family, school, church, play-group, social class, community. This does not mean that constitutional and physical factors are to be overlooked.

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26 Brown, J. F., Psychology and the social order. McGraw-Hill Book Company, 1936.
----- ----- , The psychodynamics of abnormal behavior. McGraw-Hill Book Co., 1940.

What the school or play-group means for a particular child will depend very much on his physical and mental status, and on his health at the time under consideration. But even these things cannot be completely abstracted from the child's position in the social field. There may be a close relation between the illness which keeps the child away from school and his difficulty in competing with other children in the school situation.

If the personality of the growing child is very largely the product of the influences operating in the social field to which he belongs, then in general terms it should be possible to make predictions from the nature of existing conditions in a social field concerning the possibilities for the personality development of children in that field. Thus when the cultural pattern of a community, the social field, is such that the basic requirements for healthy development of children can be met, one will expect an optimum of successful adjustment and general well-being. But when such conditions do not exist, one will expect all sorts of behaviour difficulties and disorders.

What are the basic needs which must be met if children are to develop satisfactorily, and to what extent are these needs being met under existing conditions? First of all, there are the needs associated with physical growth and development, which also concern of course the entire personality. These are needs for adequate diet, exercise, sleep, protection against

infection, fresh air and sunshine, and so on. Certainly under the existing social organization, particularly where a state of war is present, many children are denied some of these things essential for normal development. Second, there are certain basic psychological needs. Psychologists agree that the two most important are the need of affection and love, and the need of security.

From our survey of the various changes within the social field, it would be quite reasonable to argue that many of the changes are in the direction of increased affection for children; for example, reforms in education. But what of security? Dr. Susan Isaacs states that "Without security, the child cannot venture to learn or to enter upon active social relations."[27] For this security at least three conditions are essential: a rhythmic pattern in the details of life; a firm control when such control is appropriate; and stable, reliable feelings and attitudes in those in the immediate life of the child. Unfortunately, it would appear as if insecurity and not security is the chief characteristic of contemporary society. We have seen that concerning marriage, the family, education, religion, industry, considerable uncertainty and insecurity exist. Consequently it is extremely difficult to provide children with the necessary

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[27] Isaacs, Susan. The importance of the child's emotional life. Education for Complete Living. Australian Council for Educational Research, 1938, 613.

pattern of life, with its rhythm, reliability and stability. If the various groups within the social field which are to be responsible for the determination of the child's personality are victims of confusion and insecurity, they cannot give to the child the security needed.

It follows from this argument that there must be many children, who, because of the nature of the changing cultural pattern, can be expected to exhibit difficulties of adjustment and even personality disorders. This is actually the case. In an investigation conducted by Dr. K. S. Cunningham in fourteen schools and institutions in Victoria he reported that "14.2 per cent of the children were regarded by the teachers as showing abnormalities of physical, mental, educational, emotional or social development."[28] The categories which provided the largest number of cases he gave as defects of personality and conduct disorders. Compared with some estimates made in other countries, Cunningham's figure is quite conservative.

The Child Guidance Council in England estimated that probably 25 to 30 per cent of the school population would benefit by expert child guidance, and that 5 per cent required definite psychotherapy.[29] A careful study conducted in

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28 Cunningham, K. S. Problem children in Melbourne schools. Education for Complete Living. Australian Council for Educational Research, 1938, 613.

29 Quoted by Dr. Susan Isaacs in The Problem Child. Education for Complete Living. Australian Council for Educational Research, 1938, 623.

Monmouth County, New Jersey, U. S. A., revealed that 39 per cent of the children in the public schools needed psychiatric study and treatment.[30] These figures are really alarming, and give credence to the deductions made from the character of the current cultural scene relative to its effect on the child. With increasing unrest and confusion in the world, we can expect an increase, rather than a decrease, in the number of children who will require expert assistance if they are to be able to overcome their difficulties and problems of personality development.

Two measures at least are essential in order to cope with the situation. By understanding the dynamics of social change, predictions can be made which will make possible intelligent social planning, which will reduce the factors making for personal maladjustments. Instances of such planning would be a greater attempt to integrate the work of the school with the needs and demands of the community; the organization of industry so as to eliminate large scale unemployment; adequate provision for the social consequences of periods of economic depression. When the present international conflict is over social planning on a simply colossal scale will be necessary, planning which can be commenced now if the dynamics of social change are understood. But however effective such planning may be, there are already and there will be in the future both

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30 Witmer, Helen L. Psychiatric clinics for children. New York, The Commonwealth Fund, 1940, 52.

children and adults, who will need for their own sake and in the interests of the community, special assistance of a psychological and psychiatric nature.

The questions of social planning and adult psychiatric services are outside the scope of the present study. To meet the pressing needs of children with problems of adjustment, conduct and personality disorders, it is absolutely essential that adequate child guidance facilities be established. Child guidance is not a community luxury to be developed by a few well-meaning enthusiasts, or by the state if and when budgets permit, for it is a basic community service quite as important as schools and hospitals. The society which neglects to provide child guidance services pays a heavy price in terms of unhappy, difficult children in the home and school, and an unnecessarily troublesome burden of delinquents, criminals, maladjusted people requiring institutional care, and malcontents who are a constant problem in any community. In the chapters to follow it will be indicated how child guidance meets the need of children for special assistance which will enable them to grow into healthy, happy adults who will be an asset and not a liability to the community. The history, theory, organization and techniques of child guidance clinics will be discussed in terms applicable to Australian conditions.

## Bibliographical Note.

Books of interest for the general reader dealing with the social changes discussed in this chapter are:

Neurath, Otto, Modern Man in the Making, issued by the International Foundation for Visual Education, Alfred A. Knopf, 1939.
Plant, J. S., Personality and the Cultural Pattern, The Commonwealth Fund, 1937; discussion by a psychiatrist of the interplay between the individual and his environment. Of particular interest to psychiatrists, psychologists and sociologists, but within the grasp of the educated layman. The proceedings of the New Education Fellowship Conference held in Australia, 1937, and published by the Australian Council for Educational Research as Education for Complete Living, 1938, contains material which will be of value to the general reader as well as to the educator.

The professional reader will find the theoretical position adopted here more fully developed in the writings of the Gestalt psychologists. Two books of direct interest, both by Professor J. F. Brown, are:
Psychology and the Social Order, McGraw-Hill Book Co., 1936;
The Psychodynamics of Abnormal Behavior, McGraw-Hill Book Co., 1940.

An excellent study of social conditions in America is found in Social Disorganization by Elliott and Merrill, Harper & Brothers Publishers; revised edition, 1941.
Personality and Problems of Adjustment by Kimball Young, Crofts and Co., 1940, is a comprehensive survey of the psychology of personality and the problems of mental hygiene; a useful source book for students and professional workers.

## CHAPTER II

## THE CHILD GUIDANCE CLINIC.

### 1. Historical Sketch.

Child guidance in the restricted sense of the provision of expert assistance for children presenting behaviour difficulties is a comparatively modern development. From earliest times little consideration was given to the peculiar needs and problems of children. The mental defective and deformed were regarded as possessed by demons or as the result of the anger of the gods, and as such nothing should or could be done for them. Consequently they were often intentionally neglected, except for periods like the seventeenth century when they were used as court entertainers. Children not possessing marked abnormalities were expected to conform to the adult demands or else be punished.

The first attempt to consider the problems of children was in the field of special physical handicaps. As early as 1620, Juan Pablo Bonet had invented a manual alphabet for the deaf which led to further work with the deaf and dumb. With the work of Itard, Séguin, Guggenbühl, Saegert and others interest began to be taken during the nineteenth century in the education of the mental defective. At the same time significant developments in education were taking place under the leadership of Pestalozzi, Froebel and Montessori, the forerunners of the movement for the child-centred school.

Towards the end of the last century, new attitudes began to take shape with regard to the adult groups requiring institutional care - the anti-social, dependent and mentally diseased. It was seen that mere institutionalizing was quite inadequate, that along with it must go a programme of therapy directed towards rehabilitation based on a thorough study of the individual case. Under the influence of Freud in Europe and Adolf Meyer in the United States (to mention two of the more outstanding workers), psychiatrists and those concerned with the groups in question, began to realize that the conditions which they were called on to treat could not be considered in abstraction from the earlier life and social conditions of their patients. The criminal or psychotic may well be simply the end product of individual and social forces operative from infancy in the life of the patient. This naturally led to a new interest in the problems of children, to see if it were possible to trace the beginnings of delinquent and pre-psychotic behaviour. Here is the beginning of child guidance.

In 1909, under the direction of Dr. William Healy, the Chicago Juvenile Psychopathic Institute was founded in connection with the Chicago Juvenile Court, in order to study delinquents and to see if they could be prevented from becoming criminals. This was a pioneer venture concerning which Healy later wrote: "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

co-ordination of studies to be undertaken in the realms of medicine, psychiatry, psychology and social work."[1] Five years of study resulted in the book which was to have considerable influence throughout the world, "The Individual Delinquent".

In the meantime there had been developing in America the National Committee for Mental Hygiene, which was engaged in a programme for the better provision for, and understanding of, the insane and mal-adjusted, and soon it included within its interest the question of preventive psychiatry beginning with the young.

The world war of 1914-18 temporarily retarded the movement, but post-war conditions produced so many perplexing problems for all those interested in the welfare of children, teachers, parents, physicians, social workers, that the establishment of special clinics for children with behaviour difficulties became imperative. Although in both Europe and America this was already being done to a certain extent, the new movement was given impetus and direction by the creation of demonstration clinics in the United States by the National Committee for Mental Hygiene in behalf of the Commonwealth Fund. From 1922 to 1925, demonstration clinics were set up at St. Louis, Norfolk, Dallas, Monmouth County, Minnesota,

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[1] Healy, William. Twenty-five years of child guidance. Studies from the Institute for Juvenile Research, Series C, No. 256, Illinois Department of Public Welfare, U. S. A., 1934, p. 2.

Los Angeles, Cleveland and Philadelphia, in that order, the express purpose of these clinics being: "1. To develop the psychiatric study of difficult, pre-delinquent, and delinquent children in the schools and the juvenile courts; and to develop sound methods of treatment based on such study. 2. To develop the work of the visiting teacher whereby the invaluable early contacts which our school systems make possible with every child may be utilized for the understanding and development of the child. 3. To provide courses of training along sound lines for those qualified and desiring to work in this field. 4. To extend by various educational efforts the knowledge and use of these methods."[2]

So successful was this programme and such was the increasing interest, that at the conclusion of the demonstration period the child guidance services had increased fourfold; and by 1935 there were 617 public clinics providing for children, of these 235 maintaining the full clinical staff of psychiatrist, psychologist and social worker.[3] While this development was going on in America, similar developments considerably influenced by it were taking place in Great Britain-

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[2] Stevenson, George S., & Smith, Geddes. Child guidance clinics. Commonwealth Fund, New York, 1940, p. 21.

[3] Witmer, Helen L. Psychiatric clinics for children. Commonwealth Fund, New York, 1940, p. 56.

and on the Continent, though the difficult political situation in Europe was soon to drive many of the leading workers to seek refuge either in Britain or America. With the outbreak of war in 1939, child guidance services were seriously dislocated in Britain; and though the war has provided opportunities for the study of particular problems associated with the child which will undoubtedly produce new insights and understanding, difficulties of finance, staff and clinical organization will represent heavy handicaps for what had been an extremely healthy and promising movement in Britain. Consequently, in America alone can child guidance continue to grow without undue interference.

The history of child guidance in Australia has yet to be made, for Australia has lagged far behind other countries in this field. As has already been indicated this is not because there is not a great need for this form of community service, but must be attributed to quite other reasons: lack of public and professional concern with the problem, inadequate training facilities and openings for people who would be suitable for child guidance staffs, the unwillingness of governments to put money into this type of community service. Some facilities however do already exist, inadequate though they may be. Psychiatric services are provided in the various Children's Hospitals, but these clinics suffer from the disadvantages associated with the hospital clinic in that they

tend to be limited to the more serious type of condition, often the reason for referral being some physical disability or illness. The child with behaviour and adjustment difficulties is not likely to be referred to the hospital, and even when this is the case, the hospital does not have the staff and facilities for carrying many such children for sustained therapy.

Apart from these hospital clinics, there are a number of agencies working in the general field of guidance. In New South Wales, a child guidance clinic was established in 1936 as part of the School Medical Service, with a staff of psychiatrist, psychologist, and social worker. In 1939, a second clinic was established in connection with the Child Welfare Department, under the direction of the Principal Medical Officer of the Department of Education. The Department of Labour and Industry conducts a vocational guidance bureau for those of school leaving age or older. New South Wales is also developing the system of school counsellors in primary and high schools, though this is still in an early experimental stage. In Victoria, in 1938 a clinic primarily for the diagnosis of mental deficiency was established at the Travancore Developmental Centre under the control of the Department of Mental Hygiene. The Victorian Vocational Guidance Centre, a privately controlled clinic, specializes in vocational guidance, but also gives a general service.

South Australia has no complete child guidance service,

though this service is undertaken by two psychologists attached to the Medical Branch of the Education Department. A psychological clinic was opened in Western Australia in 1928, but was closed in 1931. A limited service is now provided by the Department of Psychology at the University, Perth. Since 1922, Tasmania has had a state psychological clinic for the diagnosis and certification of mental defectives.

Although there are psychiatrists, psychologists, educationalists and others who do a certain amount of child guidance, the above mentioned agencies are the only ones attempting to provide facilities for community child guidance in the modern sense of the term. Mention should be made however of work that is being done with the pre-school age groups.

Closely related to the work of child guidance is that done by the nursery schools and kindergartens in Australian cities; but owing to lack of funds, restricted staffs and facilities, only the fringe of the pre-school child population is being touched. The establishing in the capital cities by the Commonwealth Government of the six Lady Gowrie Child Centres under the administration of the Australian Association for Pre-school Child Development marks an important advance in work with the pre-school age-group. These centres are for the purpose of demonstrating programmes for the promotion of the physical, mental and social development of pre-school children, and as centres for research and investigation. Like the Kindergarten Unions they will not provide for children

presenting serious behaviour problems. These centres will greatly further the objectives of mental hygiene, and should be responsible for reducing the amount of maladjustment in Australian children. But as they are not prepared to deal with children presenting conduct abnormalities, experience in these centres is likely to demonstrate the extreme inadequacy of Australian child guidance services. The development of these centres on a commonwealth rather than a state basis, establishes a precedent that child guidance could well follow.

In a survey of child guidance in the United States, Stevenson and Smith reported that in their opinion (one shared by other authorities also) for every 200,000 of the population there is the need for, and the possibility of, maintaining one fully staffed child guidance clinic.[4] On this basis, Sydney needs six such clinics or their equivalent in services; Melbourne five; Brisbane, Adelaide and Perth at least one each. This would cover only half the population of Australia, leaving the greater part of the rural and country town population without the necessary services. To cope with this situation, some system of travelling clinics would be required. Arbitrary as this statistical basis for determining the extent of needed services may be, there is nothing to indicate that it is an over-estimate. Surely child guidance in Australia

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[4] Stevenson & Smith., op. cit. (n. 2), 134-135.

has been sadly neglected.

2. The Philosophy of Child Guidance.

Although it is rather difficult to outline the philosophy of child guidance in the way that one might outline the philosophy of Descartes or of democracy, it is possible nevertheless to present some of the most significant attitudes and trends of thought which have the assent of the great body of workers in the field, and which with some justification may be called the philosophy of child guidance. The development of thought in this matter, like that of its kindred subjects, has been from narrow, limited, static concepts, towards concepts increasingly broad, more inclusive and dynamic in character. This evolution is very largely the result of the changes that have been taking place in the various professions from which child guidance has drawn its personnel and the greater part of its theory and techniques.

As child guidance had its beginning within the borders of psychiatry as child psychiatry, and as such was studied in order to see what light could be thrown on adult conditions, it was only natural that it should be thought of in the terms of the prevailing psychiatric and medical concepts of classification and symptomatology. Psychology was not in a position to contribute to this study, even if such assistance had been asked for. The psychology of fifty years ago was deeply immersed in sterile academic controversies which had

little, if any, bearing on the problems of personality and adjustment. Social work as a profession had yet to be born. However, with the growing interest in the problems of delinquency and social maladjustment, and the introduction of more dynamic concepts into both psychiatry and psychology as the result of a new movement in the social sciences in which Freud was an outstanding figure, more attention began to be given the factors which were considered psychological.[5] Inspired by the work of Binet and Simon, the devising of mental tests became a new occupation for psychologists, and clinical psychology gradually assumed its place under the at first distrustful eye of the psychiatrist. Generally, the medical man combined both the offices of psychiatrist and psychologist. From the start of Healy's work in Chicago onward, attention was directed towards the social factors contributing to problems under consideration, but this interest was necessarily inclined to be of the arm-chair variety, as the trained psychiatric social worker was not yet available.

Although as early as 1905 social workers were being employed in hospitals, the general body of social work remained a matter of organized charity, motivated to some extent by other motives than that of benevolence. Writing of pre-

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5 The increasing influence of psycho-analysis is demonstrated by a series of articles in The Journal of Abnormal and Social Psychology, 1940, Vol. 35, January, April, July. Symposium: Psycho-analysis as seen by analyzed psychologists. The contributions by J. F. Brown, Henry A. Murray and Franz Alexander are particularly interesting.

World War social work, Bertha C. Reynolds says: "Society had a need to place outside of itself those who were not economically successful, and employed social case workers to see that it was not troubled by these individuals and their families."[6] That this is still the case to some extent is suggested by the fact that many social service agencies are virtually maintained by subscriptions from those most responsible for unemployment and economic distress in the community. However, as social work began to develop on the side of psychiatric work, with the provision for special training in this field, the psychiatric social worker was able to join the clinical team and bring her particular contribution to the study of child guidance. So when the demonstration clinics mentioned earlier were set up, the staff consisted of the full clinical team, psychiatrist, psychologist and social worker.

With the necessary development of these three professions having reached a stage where co-operation was possible, an adequate philosophy of child guidance could now be formulated. Thus Dr. George S. Stevenson, in the study from which we quoted earlier, in discussing the function and orientation of the guidance clinic gives what can be regarded as an acceptable philosophy of the clinic. The child guidance clinic is "an agency for bettering the adjustment of children to their immediate environment, with special reference to their emotional

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[6] Reynolds, Bertha C. "Re-thinking social case work." Social Work Today, 1938, p. 5.

and social relationships, to the end that they may be free to develop to the limit of their individual capacities for well-balanced maturity."[7] This goal will be sought by means of the direct study and treatment of the mal-adjusted child and of those adults whose attitudes may be adversely affecting appropriate adjustment. As the child is part of a larger community than the home or school, where there may be manifested undesirable attitudes and behaviours, along with the treatment of individuals there must be a programme for the "treatment" of the community under what can be summed up as education in "mental hygiene". Stevenson concludes then that "The case and the community are the two foci of child guidance service, and whatever the clinic does or attempts to do may fairly be judged by its effect on both."[8]

What are some of the more important implications of the foregoing statements concerning basic attitudes for child guidance? Let us briefly consider some of them.

1. The emphasis is on the giving of assistance in adjustment, rather than the giving of positive guidance as such. In fact the term "child guidance" is almost a misnomer, for the process is really one of child "adjustment", though the

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[7] Stevenson & Smith., op. cit., p. 53.

[8] Ibid., p. 54.

latter term may be too closely associated with a type of technique which to many may have the suggestion of a superficial manipulation of environmental factors. Consequently, it is preferable that we use the established term, child guidance, which does not give any hint of a particular technique and leaves room for the great variety of possible approaches.

It is necessary however to emphasize the fact that it is not the job of the clinic to give guidance other than that which may be required during the progress of treatment. The task of the clinic is to enable the individual to adjust to the particular demands of his daily life in the community with the optimum of well-being. It is not the function of the clinic or any individual staff member to give specific directions concerning moral, religious, political and other forms of belief and attitude. Not only would this be an infringement of professional etiquette and be taking advantage of the relationship established for the purpose of therapy; it would also be likely to prejudice the outcome of the therapy itself. It was for this reason that Freud and his followers insisted on the objective, impersonal attitude of the therapist, and the need for avoidance of didactic and moralistic attitudes. Although there may be rare occasions when positive instruction is indicated, the primary concern must always be with helping the child or adult to such a stage of independence and stability at which free decisions are possible. This is not to say that

the clinical staff are not to have definite personal convictions in matters of morals, religion and politics, or that they should attempt to conceal such convictions, but simply that they should in no way attempt to use their position to influence the individuals with whom they deal in a professional capacity. Of course if a clinic is under the direction of an organization, such as a church, with definite and recognized beliefs instruction and advice in accord with such beliefs would be in order, though the question as to whether this would be desirable from the point of view of therapy still would remain to be decided in each case.

ii. The approach to the individual must be realistic, and the problem considered in terms of the actual and immediate situation, not according to what one would like or what one might feel ought to be the case. Although treatment usually must be given in the clinic and this may present a definite problem of adjustment, it is the real life situation of the individual child in which the adjustment has to be made. It is very easy to be so interested in the child's adjustment and behaviour in the clinic that the real situation outside is pushed into the background. Not only must the situation in which the child has to make adjustment be realistically considered, the child also has to be accepted realistically. Now this sounds all very obvious and unnecessary to be said, but unfortunately this is not so. How easy it is for workers to get mental sets which determine the way they view the child!

Thus the boy with difficulties of adjustment in the school and with impulsive, destructive conduct in the home, and who is found to have an intelligence quotient of 81, may be regarded as little more than an I.Q. 81 with arms and legs. There are still those who regard delinquency as due to the activity of this or that instinct, as if stealing were due to an acquisitive instinct that somehow or other had taken over Little Johnny. And some psychiatrists are still not free from the habit of regarding people as glandular dysfunctions or perambulating physical types.

In the days of atomistic thinking in the sciences this kind of attitude was understandable, but now that the necessity for a field theory has been established (in psychology due to the work of the Gestalt school), attempts to explain behaviour in terms of this instinct or that gland with little consideration of the whole person in the total situation must be rejected as unrealistic and unscientific. Kurt Lewin, one of the leading figures in this development in psychology, explains the basic statements of a field theory of behaviour as follows: "(a) behaviour has to be derived from a totality of co-existing facts; (b) these co-existing facts have the character of a 'dynamic field', in so far as the state of any part of this field depends on every other part of the field."[9]

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[9] Lewin, Kurt. "Formalization and progress in psychology." Studies in Topological and Vector Psychology, Iowa Studies, 1940, p. 42.

Consequently there is no one-to-one relationship between a particular cause and an effect, as for example between the action of an "instinct" and a certain kind of behaviour, for behaviour of people, as of all other things in the universe, is the result of the total field of which the individuals are parts. As Lewin expresses it "behaviour (B) is a function of the person (P) and the environment (E), $B = F(P,E)$, and that P and E in this formula are inter-dependent variables."[10]

In simple terms this means that the child must be regarded as a totality of individual-and-environment. Thus no mere catalogue of school marks, test scores, measurements and the like, helpful though they may be, will give a true picture of the child and the nature of his problem. To obtain a meaningful account of the child it is necessary to see him as a member of a family, school, street play-group, and other groups in which he has varying membership character, living under certain economic and social conditions in a particular district, which in turn derives certain characteristics from the larger community.[11] This does not simply mean the gathering of data

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[10] Ibid.

[11] C. R. Rogers in The Clinical Treatment of the Problem Child, Houghton Mifflin Co. (1939), develops a somewhat similar point of view in what he calls the component-factor method, an attempt to evaluate the influence on behaviour problems of eight major factors - heredity, physical condition, mentality, family environment, economic and cultural conditions, social factors (companions etc.), education, the child's present insight into his behaviour. "To understand behaviour we must view it as the complex result of all these component factors." (p. 40).

concerning the size of the family and the status of the members, the nature of the school, the conditions of the neighbourhood, and all the detailed and extensive case and social history usually taken as a routine in most child guidance clinics. What is essential is that these data be understood in terms of the dynamics of the situation. What is the meaning and influence of these various factors in the total psychological field of the child? Two apparently identical situations may have quite different significance for two different children, or for the same child on different occasions. Why do children of the same family for whom conditions may be apparently similar develop so divergently? If slums cause delinquency as is often argued, why do some slum children become delinquent and others under equally bad slum conditions become good citizens? The answer to these and similar problems which face the child guidance expert can only be found when they are understood in the light of the dynamics of the entire field, no single part of which can be fully understood as a fragment taken from the totality of the field.[12]

This approach is not to be confused with a sort of environmentalism which does not give due place to hereditary and organic factors, for these are inalienable parts of the field

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[12] This approach has been discussed in connection with the causative factors of delinquency by Nathaniel Cantor, "Dynamics of Delinquency," American Journal of Orthopsychiatry, October 1940.

which includes the person. As will be seen later, this theory of the total nature of the child and the psychological field will have direct bearing on the type of therapy undertaken. The fundamental thing is that from the beginning the approach to the child and his problem be free from the atomistic and mystical appeal to intelligence quotients, instincts, traits and so forth, and that it should be undertaken according to a realistic appreciation of the dynamics of the entire field of which the child is a functioning part. This does not exclude the necessity for the various analytic, testing and measuring devices, both physical and psychological. But the results of these if they are to be of real value need to be seen against the dynamics of the person and his field as a whole.

iii. One further implication in the statement of Doctor Stevenson that we quoted as a summary of child guidance philosophy calls for comment. The two points discussed above concern the attitude taken towards the child. This third point concerns the attitude to be taken toward the community. As has been indicated, to understand the child an accurate understanding of the community of which he is a member is necessary, hence no ivory tower attitude is possible. But more than this, the child guidance clinic is concerned with the community for its own sake. Stevenson wrote of the need for the clinical staff to spread the concepts of mental hygiene throughout the agencies dealing with children, and throughout the community

as a whole. It will be recalled that this was one of the specific functions of the Commonwealth Fund Demonstration Clinics to which reference has been made. Stevenson went so far as to suggest that the effectiveness of the clinic was to be judged not only according to the results achieved with individual children, but also according to what had been achieved with the community.

There are a number of very good reasons why this should be so. For the sake of the mental health of the entire community the spreading of mental hygiene is desirable; and to make possible more satisfactory development and adjustment of children which is the peculiar concern of the clinic, it is necessary to change by education the attitudes held by the community or sections of it which are detrimental to this development. Moreover, however effective the work of the clinic may be, there will be many children who will not be reached by its services, and who can only benefit indirectly through the education of those responsible for them, their parents, teachers and other adults who are part of their lives.

But this is not all. Child guidance in itself is necessarily very limited in what it can accomplish. Speaking in relation to delinquency, a major concern of child guidance, Dr. William Healy after extensive experience comes to the conclusion that: "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 child guidance clinic may be of great aid in a program for the prevention of delinquency remains thoroughly valid, but indispensible 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."[13] And it may well be added, the modification and alteration of those institutions which express this community spirit or ideology.

It may not be the special function of the clinical staff to play the role of social reformers or advocates of particular political, economic and social changes. They have however a responsibility to see their work against the wider mental hygiene background, and to make public the facts which they have discovered concerning social and economic conditions that are contributing to the creation of delinquents and making difficult the happy development of both children and adults. And yet it is surprising how many workers are neglectful of this responsibility. A prominent American sociologist at a recent conference dealing with problems of adjustment, in criticising

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13 Quoted by Helen L. Witmer., op. cit. (n. 3), p. 296.

this position which the writer had suggested declared that "I am not interested in social theories or in developing a social philosophy; I regard myself as an individualist sociologist"; a strange confession for a sociologist.

The child guidance clinic needs to keep in close contact with the community not only because of its need to understand it, and for the adequate prosecution of a mental hygiene programme, but also because the actual existence and conduct of the clinic ultimately depends on the community. The experience gained in America, particularly during the stage of the demonstration clinics, has clearly shown the need for very close co-operation between the clinic and the community. Before the clinic is established it is essential that the community be prepared for it and the need for it recognized. It should not be introduced as something thrust upon the community, and irrespective of the particular and more urgent needs of the community. Where the financing of the clinic is going to be carried directly or indirectly by the community, this understanding and interest is necessary in order to give a reasonable chance for the new enterprise to succeed and survive. Since much of the work of the clinic will require active co-operation with various agencies already well established, schools, churches, children's courts, social agencies of different kinds, hospitals, medical practioners, the support and interest of these should be gained before the clinic is set up, and once it is gained should be carefully fostered. Fortunate is the clinic that really has the active support of all

the other agencies in its community; for regrettable though it may be, the sad fact is that often professional jealousies, prejudices and suspicions make real co-operation difficult. When the child guidance clinic is the last in the field, its staff will require a good deal of tact, patience and genuine goodwill, if friction is to be avoided.

There are many potential trouble spots: unsolicited newspaper publicity which ignores the work done by agencies already working in the field; tactless criticism of work done by ignorant though well-meaning people; the taking of cases for free service from agencies depending on fees for their maintenance. Every community and situation has its "difficult" people and possible sources of trouble. As far as possible these should be understood in advance and steps taken to avoid any unpleasantness which might interfere with the 100 per cent functioning of the clinic. The clinic is essentially a community service, and as such should do all in its power to achieve maximum usefulness.

### 3. Possible Auspices for the Clinic.

Having considered the historical development and basic philosophy of child guidance, we are now in a position to discuss the more practical matter of the control and maintenance of clinics. Should the clinic be under private or state auspices, what bodies could sponsor and adequately support a clinic?

#### 1. Private Auspices.

There is no reason why private individuals or some society or group of people should not establish a clinic. The question is could they? The question is primarily a financial one. The recognized minimum staff for a clinic consists of one full-time psychiatrist, one full-time psychologist, two full-time psychiatric social workers, probably two full-time clerks (the secretarial and office duties of a clinic are usually very heavy). If these are to be adequately trained and competent people, they must be paid accordingly, otherwise there will be difficulty in keeping a staff together long enough to build a real clinical team. The efficiency of a clinic depends a great deal on the quality of the team work, and this team work cannot be developed with a constantly changing staff. In addition to salaries, there are the operating expenses for rental, equipment, stationery, heat and light, fares for the social workers and so on, all of which represent a fairly big budget. In America the expense of the services indicated above are estimated at about $20,000 per year, somewhere between 4000 and 5,000 pounds.[14] It is impossible ordinarily to obtain anything like this amount by fees, for the yearly intake of new cases averages about 300, and the cases often requiring the greatest amount of service are those least able to pay. If the intake of cases were limited strictly to those able to pay fees sufficiently big to maintain the clinic, then

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[14] Stevenson & Smith, op cit., p. 55.

there would still be need for a further clinic to serve those unable to use the first clinic. For those able to afford fees commensurate with the service, there are private psychiatrists who provide competent service. The need is obviously for clinics that can take cases irrespective of their financial position.

The private clinic then can only function satisfactorily if it has an income from sources other than the collection of fees. This income could be provided by an organization which may decide to sponsor a clinic, perhaps with an objective specifically related to the nature of the organization. Thus a group of private schools could maintain a clinic for the children attending such schools. A Church or a number of Churches could maintain a clinic which might serve not only children of the denominations concerned, but the wider community as well. An excellent example of a church clinic is the Notre Dame Child Guidance Clinic, Glasgow, which is under the direction of the Sisters of Notre Dame, and is able to give service to children whatever their religious affiliation. Not only is it supported by various grants and private donations; it is able to maintain a complete clinical service because of the assistance of fully-trained honorary workers. While churches in Australia continue to conduct institutions for children, delinquent, orphan and otherwise, often without suitably trained staffs, it would seem highly desirable that such institutions should have ready access to the services of a child guidance

clinic. This is an instance where several churches might unite in the common enterprise.

Clinics which serve the general community and which are private in the sense that they are not financed and controlled by the government, are generally dependent directly on substantial grants from some foundation, like the Commonwealth Fund, on endowments and donations. Thus the 1935 census of clinics in the United States revealed that 30 per cent were financed in this manner.[15] Some people prefer this type of arrangement, where the clinic is relatively free from the intrigues of politicians and party politics, and free from the restrictive tendencies of bureaucratic government department administration. Often when the state is too slow or unwilling to establish child guidance clinics, it will be necessary for private individuals or organizations to take the initiative in establishing them. However there is much to be said in favour of public, that is state, auspices for the clinics rather than private as discussed above. Nevertheless so much depends on local conditions, that each situation must be decided accordingly.

ii. State Auspices.

Let us first consider some of the advantages of the state maintained clinic. The question of political interference is not as important as sometimes is argued, for the private clinic

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15 Witmer, Helen L., op. cit., p. 57.

may be subject to equally disturbing influences. A board of management can prove very difficult, and personal issues are liable to play an undesirable role, particularly when a clinic is greatly indebted to the financial support of an individual or group desiring to influence policy in a manner not acceptable to the professional staff. He who pays the piper can call the tune.

The state clinic is maintained by the taxes of the people, and is controlled by their representatives on their behalf. Consequently if a clinic is not giving proper service to the community, if it is subject to unwise or unfair interference, if the staff is unjustly treated, then the people have the constitutional means of making their will known, and ultimately of making it effective. Of course graft and bad administration are not unknown in Australian state departments, but it is doubtful whether it occurs more often there than in private undertakings where it is more difficult to detect and deal with. There is an increasing public opinion that the health of the community is a government's direct concern, that it should provide all the services necessary for the health of the whole community, especially that of the children. It would seem that this applies to their mental health as much as to their physical well-being (if they can be separated), and that the provision of child guidance clinics is the logical step in this direction.

Probably the strongest reason in favour of the state clinic is that it guarantees a certain stability and continuity for

the clinic. The death of a wealthy supporter, the withdrawal of a grant by some foundation or organization, a decline in public interest and support may cause the private clinic to fold up or at least to seriously curtail its activities. No clinic can do its best work when its future is so uncertain. But the state clinic once well-established cannot be so seriously affected. A severe economic depression or war may lead to some temporary restriction of activities but in the same situation the private clinic might have to close down completely. Not only is the state clinic as an institution more secure; the staff also has greater security than the staff of the private clinic. The conditions of employment by the state are on the whole better than could be offered by a private institution. Salaries, working hours, holidays, superannuation and most matters pertaining to a position are clearly defined and give the employee security and protection. Though he is free to leave the service, as long as his work is satisfactory it is extremely difficult for the government to dismiss him. Consequently, the staff of the state clinic is much more likely to remain with the clinic than is the case with the private clinic, which would make possible the developing of good team work and a consistent, sustained policy.

This keeping of a staff together for relatively long periods is very important for research. Every clinic, however heavy its case schedule, will carry out investigations which can be given the dignified title, research. Some clinics will

be able to set aside special workers to pursue definite research projects. But in any case research will be greatly facilitated when there is some continuity and constancy of staff members. Much of the most significant research work in child guidance clinics must be spread over a period of years, such as studies of change in intelligence quotients, evaluation of treatment techniques, prediction of personality development and so on.[16] It would seem then that the state clinic with its fairly permanent staff should be able to undertake research studies which would be difficult in a clinic subject to frequent staff changes.

There are of course certain dangers to be guarded against. Incompetent people may be retained on staffs and even promoted to responsible positions because of political influence. Staffs may become so institutionalized that they lose some of the personal touch that is valuable in this work; and they may tend to get into a rut and fail to keep abreast of modern developments because they feel secure in their positions and are not forced to compete with the other workers in their field. Staffs may guard against this tendency by regularly reading professional journals, by attending such professional meetings as may be held, and by making use of every means existing for exchange of ideas and experiences between workers in the same

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[16] An example of this sort of research is reported by Dr. William Healy and Dr. Augusta Bronner. Treatment And What Happened Afterward, Judge Baker Guidance Center, Boston, 1939. This is concerned with the results of the follow up of 400 cases, five to eight years after treatment.

and related fields. In this regard, there is need in Australia for some professional association which would bring together psychiatrists, psychologists, social workers and other professional people concerned with mental hygiene. An excellent example of such an organization is the American Orthopsychiatric Association, which is contributing considerably to the development of co-operation between psychiatrists, psychologists and psychiatric social workers, and by its publications and meetings is doing much for the education and stimulation of those engaged in the field of mental hygiene. A similar professional body would be extremely valuable in Australia, particularly in view of the disadvantages suffered by Australian workers because of their isolation from the rest of the world.

The state clinic has a status and authority that other clinics may not have. This is important for several reasons. Because of its position, it is easier for the state clinic to gain the co-operation of agencies in other government departments or in the same department, often necessary in dealing with a case. It may be necessary for the clinic to deal with police officials, court magistrates, housing authorities, school staffs, to obtain the admission or discharge of a child from a state institution. These are but a few of the routine matters in which the state clinic can operate more efficiently and expeditiously than would be possible for another clinic. The position of the state clinic makes it possible for expert advice to be directed to the right administrative quarters

in matters concerning mental hygiene. In this way important legislation can be affected (it must be admitted that legislators are strangely adverse to accepting the advice of professional experts). For example, the revision of the Mental Deficiency Act (1939) in Victoria incorporated certain suggestions made by the staff of the Travancore Clinic (Department of Mental Hygiene) which had had the opportunity of special study and direct clinical experience. This sort of co-operation between legislators and professional people is certainly needed, and is probably more likely to come from the kind of situation we have outlined than otherwise.

One further consideration is that child guidance is not a matter of just one clinic or a number of clinics, but is part of a larger mental hygiene programme, a programme requiring careful planning, integration of activities, provision for future developments and the guarantee of ever widening and growing service. This can only be provided by the state with the resources, organization and continuity that no private body possesses. There is need, for example, of some kind of travelling clinic to serve districts that the city clinics could not reach. It is most improbable that any private clinic could afford to carry such an undertaking in which overhead expenses would be proportionately greater than in the city clinic.

It can be concluded that though there are situations in which the private clinic can be satisfactorily developed, perhaps more advantageously than the state clinic, from the point of view of the security of the staff and the clinic, and

with respect to the service to be given to the community as a whole in the general programme of mental hygiene, the state maintained and controlled child guidance clinic is to be preferred. If this be so, then those wishing to see an extension and adequate provision of such services would be well-advised to direct their efforts towards educating public opinion concerning these points, and to bring all possible pressure upon legislators and government departments that appropriate action may be taken.

If the child guidance clinic should be under state control, what department is best fitted for the task? Though this is rather an awkward question, experience abroad does furnish us with information helpful in attempting to find an answer.

The Education Department.

At first thought the most appropriate place for the child guidance clinic would seem to be within the school system. There are several reasons which give strong support to this arrangement. More than any other department, education has to do with the everyday life of children; all children go to school (with the exceptions of certain relatively small groups), and spend more of their waking time in school than in any other one place. Many of the problems for which children are referred to a clinic are directly concerned with school, and many not directly concerned with school will nevertheless be revealed in the school situation. The school staff not only

has a great deal of useful information about the child; it also is in a position to gain information concerning the home and parents of the child, his play mates and his out-of-school behaviour. It is significant that a high percentage of the referrals to most clinics come from school authorities, often in cases where the parents either were unaware of any difficulties or else were indifferent to them.

Not only is this close relation between the school and the child valuable for early diagnosis of behaviour and other difficulties; it is also of considerable advantage in treatment. Often the clinic needs to recommend specific changes in the school situation - perhaps a change of class or school, increase or decrease of pressure in schoolwork, special coaching in weak subjects, some alteration in the type of course being followed, modification in the existing teacher-child relation and so forth. Such changes suggested by the clinic are more likely to be accepted if the clinic is within the school system and in direct communication with the school concerned. The school clinic not only has this readier access to the schools and their staffs; the latter in turn are able to make more use of the clinic and profit personally by this contact.

This arrangement will also have some appeal to administrators. It may well be that existing buildings under the control of the education department could be used for clinical purposes, and that teachers and officers already in the depart-

ment could be used on the staffs, both measures possibly representing some economy in planning and finance. Moreover, it would be possible to integrate this new service with already existing services, dental, medical and otherwise, obviously a desirable thing. Consequently there is a strong argument for the developing of these clinics within the school system, an argument which has found favour in a good many cities in different parts of the world, and has led to the building up of some fine clinics such as those under the Board of Education of the City of New York.[17] However the whole matter is not quite so simple and straightforward, for there are other factors which weigh heavily against such a scheme.

As far as Australia is concerned it is necessary to remember that 26 per cent of children are educated in private schools, and that if clinics were established by the Education Department provision would still be needed for these children.[18] Even if the state school clinics were open to private school children, there would be the tendency to give preference to the state school children; while at the same time private schools may have some hesitation about sending their children to the state school clinic.

There are further objections to articulation with an education department of a more general and fundamental nature.

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17 Understanding the Child, Jan. 1939, is devoted to a series of articles on mental hygiene in New York City schools.

18 Australia Today, 1940, p. 22.

Though it is true that many of the problems presented by children are either primarily school problems or else are first manifested in the school, and that teachers can contribute material useful in diagnosing the case and suggesting treatment, these very facts involve certain disadvantages, even dangers. The problems which teachers may consider most needing attention and for which they might most frequently refer children will not necessarily be those which really do require attention most urgently. A number of studies on the subject indicate that there is rather a startling contrast between the rating of conduct disorders by teachers and psychiatrists.[19] It can be easily understood that the teacher with a big class will regard the very active, noisy child as a problem, and the quite obedient, seclusive child as a model pupil; whereas the psychiatrist may regard the first as a perfectly healthy, normal child, and the second as a child in need of treatment. Too easily can the school clinic become a kind of dumping ground for children that teachers find hard to manage, while children really in need of child guidance service can be crowded out.

The advantages that the school clinic has from the point of view of the understanding and treatment of the child are not as great as imagined. Certainly it is relatively easy for such a clinic to obtain data from the school, and to make

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[19] See Children's Behaviour and Teachers' Attitudes by E. K. Wickman, Commonwealth Fund, New York, 1928.

necessary changes in the school as the treatment programme demands. This may be of doubtful value however, particularly when the problem is closely related to the school situation, for both the child and the parents may regard the school clinic with some suspicion, and be unwilling to co-operate. The parent may dislike discussing intimate family matters with the clinician if he or she feels that the material may be seen by the teacher or members of the local school staff. Not infrequently parents and children believe that the school is at fault, in which case they may not feel free to discuss the problem with anyone who they might feel was too closely related to the school and the pupils as such. Teachers can provide very valuable data concerning the child referred to the clinic, and whenever possible such material should be obtained, but it cannot take the place of the report of the psychiatric social worker. Teachers are not trained to obtain social histories and to understand the dynamic factors involved in a situation, and though some through special training and experience may be able to do this competently, generally they will tend to give material as viewed from the school approach rather than from that of mental hygiene proper.

With regard to the using of school buildings and staff caution is necessary. The clinic should be free from the school atmosphere, which may be difficult to achieve if the clinic is housed in the same building as a school, though a good deal will depend on the particular situation.

The using of staff from the school system presents a more likely hazard. Experience has shown, if any demonstration were required, that the school medical officers cannot act in the capacity of clinical psychiatrist. Even if they had the special training in psychiatry and child guidance, and this is rather unlikely, other duties with which most of them are already overburdened, would make the proper carrying out of their additional duty virtually impossible. The clinic should have a psychiatrist with the necessary qualifications who can give the clinic undivided attention, and who should be responsible for its direction, and for all matters of psychiatric character.

Generally speaking it is not a good plan to appoint teachers to positions as clinical psychologists. Their training is apt to give them a bias in the direction of educational attitudes rather than mental hygiene (admittedly there should be no real distinction here, but unfortunately quite often there is), with an inadequate appreciation of the psychiatric and social factors involved. Of course for such purposes as remedial reading, speech correction and coaching backward children, those with training in education can be most useful and perform an essential service. The Glasgow Corporation Child Guidance Clinics are under the control of the education authorities, and have been staffed from those already within the school system; and although in this particular situation there appear to be certain advantages to such arrangement, in

the writer's opinion it is not a thoroughly satisfactory set-up.[20] The psychiatric work is done by the school medical officers as required by the psychologists, and not as a routine. The psychologists who have been trained as educational psychologists carry almost the entire clinical programme. There are no psychiatric social workers, it being considered that this work can best be done by the teachers or the clinical staff as time permits. The dangers in such an approach will be apparent to all with any experience of child guidance, and demonstrate the inadvisability of education authorities directing child guidance unless care is taken to see that the clinics are in line with the recognized standards and procedures.

If clinics are established outside the education department, this doesn't mean that close co-operation between the clinic and the school is not desirable and possible. However, such co-operation is not something that will just grow whatever the staffs may or may not do; it will need careful fostering if it is to be really worthwhile. The clinic can learn a great deal from the school staffs who work and play with the children, and the schools in turn can benefit from the insights and mental hygiene instruction which the clinical staffs can give to them.

The University.

This is a convenient point in the discussion to mention

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[20] The Glasgow clinics were visited by the writer in October 1939.

the possibilities for clinics under the direction of university authorities. Clinics are quite effectively conducted by psychiatry, education and psychology departments in a great many of the universities in Europe and America. There are certain advantages in such a scheme. Association with the university gives the clinic an acceptable status in the community, an important matter particularly for a new clinic. Contact with the relevant university departments enables the clinical staff to keep in touch with the latest work in the fields concerned (sometimes it will be necessary however for the clinical staff to do this for the university staff). The fact of the clinic being under university control will facilitate the training of students in psychiatry, psychology and social work, and will give them ready access to material useful for research in the different aspects of the work. The university clinic may help to some extent to bridge the gap which often exists between the university and the community, an important service when the university is dependent on the community for its support by means of taxation and subscriptions, as in Australia.

There are at the same time a number of dangers to be avoided. Instead of a clinic being a co-operative effort on the part of the departments concerned, it can very easily become a source of division and departmental jealousies. Departments sometimes go so far as to run rival clinics which display a critical and almost hostile attitude to each other. It is

preferable that in addition to the members of the university staff who may assist in the clinic there should be full-time clinical officers responsible for the maintaining of the clinic, and able to carry on the service during vacations and at other times when the academic members cannot devote the necessary time to the clinic. In one American clinic staffed entirely by members of the university faculty, cases are closed on the approach of the vacations, irrespective of whether this is desirable or not from the standpoint of the case!

Where students are assisting in the clinic or having access to case records for the purposes of research, care must be taken to see that the confidences of clients are not being disregarded. In the clinic mentioned above (and this is in one of the better known and most reputable of American universities) material given in confidence is in grave danger of becoming almost public property, a serious thing particularly if the community is a rather small one in which clients may well be known to the students.

Whether the association with the university be a direct one or not, some kind of affiliation with it seems to be advantageous both to the clinic and the university. Stevenson and Smith sum up the situation thus: "Speaking broadly, affiliation with the university enriches the opportunities of the clinic without robbing it of its community frontage. . . Functionally, the relationship opens the way for the clinic to influence (through formal teaching) the development not

only of psychiatry but also of psychology, social work, and sometimes the law and the ministry as well."[21]

The Penal Department.

As indicated earlier in this chapter, historically there was a close connection between the development of children's courts and child guidance.[22] Much of the pressure which was exerted in favour of child guidance came from the recognized need of reducing the number of delinquents, and of preventing juvenile delinquents from becoming adult offenders. In Australia much of the talk concerning psychiatric clinics arises from a similar attitude. Public opinion is beginning to realize that the provision of children's courts is in itself not doing very much to reduce the amount of delinquency. There is a growing reaction against the commitment of children to reformatories and similar institutions, and magistrates are generally inclined towards giving probation rather than commitment.[23] This of course merely raises the further problem of what is to be done with delinquents on probation. Consequently, any action taken concerning child guidance will undoubtedly be related to the need of psychiatric investigation and treatment for children appearing before the courts, or

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21 Stevenson & Smith, op. cit., p. 137.

22 Healy, William. The Individual Delinquent, Boston, Little, Brown & Co., 1915.

23 Barnet, F. Oswald. The making of a criminal. Stuart Taylor, Melbourne, 1940.

coming into conflict with the Law. Should then the child guidance clinic be under the auspices of the Children's Courts or some branch of the Penal Department?

Again we have the objection that was brought against the school system as the controlling authority, namely that though there is need of provision for delinquents, the need is for clinical services not only for those within a school system or those appearing before the courts, but for the entire juvenile population. A clinic in anyway associated with the courts or the Law would carry with it an unpleasant connotation, and parents would be unwilling to take their children to such a clinic lest they should in some way be considered as delinquent.

Would it be desirable to maintain a special clinic for delinquents? This is probably also an unwise procedure. If the clinic is directly connected with the courts, neither parents nor their delinquent children will feel free to co-operate because of fear that what they say might be used in evidence against them in the court, though of course this point may hold wherever the clinic is and under whatever auspices; but at least it will be at a minimum if the clinic is not connected with the court. As many of the children will attend the clinic for treatment perhaps for many months after their court appearance, it is desirable in the interests of treatment and in fairness to the child that the court be forgotten, and that the treatment be regarded as apart from the court and its action. This is impossible if the clinic is in the same building as the court, as may well be the case, or if the clinic

is known as the clinic for delinquents. Whatever fancy name may be given the clinic, if in fact it is for delinquents, this soon will become generally recognized and will carry the same connotation irrespective of the official title.

If then there are to be no separate clinical facilities for delinquents, and the control of the clinic or clinics is not to be with the courts and the penal department, two important points must be made. The staffs of the clinics must be in a position to be able to take cases for examination at the short notice often necessary in court cases. Clinics often have appointments booked weeks ahead so that it is impossible to accept cases not provided for. If the clinic is to be in the position where it can give immediate attention to a court case, then the staff must be quite adequate not only for general community service, but also for the special demands of the courts. Further, such clinical service will be of little use if the recommendations of the clinic are disregarded by magistrates who may not appreciate expert advice, and if there is not active co-operation between the clinic and the probation officers and others responsible for the follow up of the child after leaving the court. Means must be found of making effective the clinical findings and suggestions.

The Mental Hygiene Department.

Since child guidance is so directly related to psychiatry and mental hygiene, both historically and in modern practice, it would seem to be a satisfactory arrangement if the Department

of Mental Hygiene were to sponsor child guidance clinics in Australia. The interest of this department in child psychiatry and mental deficiency, and its experience with adult mental hygiene, make it worthy of consideration. However, the situation contains some major obstacles difficult to overcome.

Unfortunately despite the best efforts of mental hygienists in recent years to eradicate the unpleasant association in the minds of the general public of mental hospitals with lunacy and incurable diseases, this still is very widespread and deeply rooted. There is still some feeling of social disgrace and loss of status felt by those who have been in mental hospitals for treatment. This being so it would be most inadvisable to have children's clinics connected, however remotely, with mental hospitals. Even the fact of being controlled by the same government department that is responsible for the insane might lead to the general public adopting prejudicial attitudes. There should be nothing concerning the nature or origin of the clinic which could give the slightest suggestion that it was intended for "silly" or "mad" children.

It is possible, however, to run a clinic in connection with a mental hospital, and yet avoid these undesirable attitudes on the part of the community. The Worcester State Hospital (Massachusetts, U. S. A.) conducts the Worcester Child Guidance Clinic with thoroughly healthy attitudes on the part of the community, and with a relationship between the clinic and the community similar to that existing any where else.[24]

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[24] Witmer, Helen L., op. cit., 149-155, 395.

This is due to the fact that the two institutions are quite separate, there being nothing about the clinic which would indicate to the public the actual relations between the mental hospital and clinic. Where this separation is possible and adequate care is taken, there seems to be no good reason why the arrangement as at Worcester should not be successful. There is an advantage in a clinic having behind it the staff resources and experience of a reputable mental hospital.

One arrangement which could well be adopted in Australia if child guidance were to be a concern of the various mental hygiene departments in the different states, is that a special division within the departments be created. Just as mental deficiency is coming to be regarded as requiring separation from the general provisions for the insane and adult patients, with a staff and training, institutions and techniques of its own, thus constituting a distinct branch or division within the wider mental hygiene organization, so too could child guidance be similarly developed within the state departments of mental hygiene.[25] If this were done care would need to be taken to see that the work and programme of the clinic are

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[25] It is interesting to note that the Victorian Mental Deficiency Act 1939 makes provision for the establishing of clinics for the purpose of -

"i. the study and diagnosis of mental deficiency and mental retardation;
ii. the examination and classification of defectives and retarded children;
iii. the instruction of members of the staff of institutions;
iv. the training of clinical and other assistants; and
v. any other purpose appertaining to all or any of the foregoing purposes."

given their right emphasis. In the past the mental hospitals and their psychiatric staffs have been interested primarily in the institutional care and treatment of patients most of whom already were suffering from conditions of a serious and advanced nature, so naturally the problem was one of a rather strictly medical and psychiatric nature. At least that was the accepted attitude. Even though the roles of the psychologist and psychiatric social worker in the mental hospital are now recognized by all competent authorities abroad, this is still far from being so in Australia where the dead hand of the old psychiatry still weighs heavily on hospital administration. Consequently any development of child guidance clinics should be free from this traditional attitude, and free to develop the well-balanced mental hygiene programme which is the task of child guidance. Child guidance is not clinical psychiatry in the older meaning of that term; rather is it prophylactic mental hygiene as it affects children in the community.

Children's Welfare Department.

The Children's Welfare Department naturally appears as an appropriate body to sponsor a child guidance programme. Certainly this department is responsible either temporarily or more or less permanently for a great many children, many of whom are in need of psychiatric and psychological examination, and of these a large percentage will require psychiatric treatment of various kinds. The volume of work would be such as to warrant clinical services for the children in the care

of the department. The co-operation already established between this department and other social agencies would be very valuable for any clinic which might be developed by the department.

But once more we see some of the difficulties already dealt with under the preceding headings. The work of the Children's Welfare Department has been with orphans, neglected and delinquent children, and is associated in the public mind with charity for this under-privileged and unfortunate group. This attitude would not be conducive to the success of a child guidance project. Even if this were not a serious factor, the very pressure of cases from the institutions and agencies of the department would tend to crowd out those coming from outside, and perhaps equally in need of immediate attention. The provision of a clinic within the above department may be essential, but there would remain a much wider child population still in need of service.

Even for the children in the care of the Children's Welfare Department outside clinical services may be desirable for the purposes of effective treatment. An outside clinic would be free from departmental prejudices which are liable to be present and which may prevent a completely objective view being taken. However administrative difficulties, local conditions such as the inaccessability of the clinic and so on, may make a clinic controlled by the department for its own purposes essential in spite of the disadvantages.

An interesting child guidance project in point here is that of the Child Welfare Services of the California Department of Social Welfare. The staff engaged in this service consists of a psychiatrist trained in child guidance, three child welfare agents, a mental hygiene supervisor, and secretarial assistants. The programme in this case is educational, not clinical. Though the psychiatrist gives some consultant service, this is not the primary purpose of his position. The objectives of the Child Welfare Services are to co-ordinate child welfare work, to assist workers in the different aspects of mental hygiene to obtain a better orientation to their work, to evaluate possible techniques and procedures, and generally to give assistance and advice to staffs of welfare, education, health and other departments concerned in the welfare of children.[26]

This type of work could be undertaken by the Children's Welfare Departments in Australia, and would make possible the laying of sound foundations for clinical services which would develop from it. It is not a substitute for regular child guidance work, as can be seen from the objectives cited above.

The Department of Public Health.[27]

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[26] Chamberlain, H. E. Report to the Children's Bureau, U. S. Department of Labor, Regarding the Child Welfare Services Program in California, Sept. 1938.

[27] While this is a Commonwealth and not a State department as those discussed earlier, the principles involved are so similar, it is convenient to deal with it without making distinctions.

So far very few clinics have been set up under the auspices of public health departments, but nevertheless a quite good case can be made out for such a development.[28] This is a department which more than any other has been interested in problems of prevention rather than cure, and so has behind it a philosophy in line with that of child guidance. For although child guidance is necessarily concerned with the curative aspects of mental hygiene, it is oriented towards more positive preventive measures. Public health departments are free from some of the unfortunate characteristics associated with the departments which have been discussed here, and is accepted by the community in a manner which would make for the uninhibited use of the clinic by all sections of the community concerned.

As this is a rather novel idea, doubtless there will be many who with some justification perhaps will feel that it is outside the province of public health. But if one has a progressive, constructive view of public health this is not the case. Surely the mental health of the children of the state, which is so intimately bound up with their physical health, is a matter of first importance to the whole community and as such a subject within the scope of any department of public health. It may be argued that the inexperience of this

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28 In Canada all the mental health work of the provinces is under the state department of health. In U. S. A. four states have established clinics under similar auspices - Maryland, Georgia, Indiana, Connecticut.

department in this work, as compared with that of certain other departments, is a definite objection to its entry into the field. But this may be all to the good. The so-called inexperience will make for a more experimental approach free from the hindrance of older professional attitudes. As has been indicated, child guidance is not simply an adaptation of psychiatry, social welfare and the other traditional approaches. Although it may have grown out of these, it now has a definite philosophy and approach peculiarly its own. It may have a better chance of healthy growth in a department not governed by pre-conceived attitudes formed from other, though related, disciplines.

It might be suggested that clinics could well be developed from services existing in children's hospitals, and though these are in need of development, on the whole it would be better for the child guidance clinic if it were quite apart from the hospital which naturally suggests the idea of sickness rather than health. Too many children have unhappy memories related to hospital experiences, either of their own or of others. At the same time close co-operation between children's hospitals and clinics should be cultivated because of the mutual assistance that can be rendered.

Although much depends on all sorts of local and particular conditions which cannot be discussed apart from a specific situation, there is much to be said in favour of the promotion of child guidance in Australia under the auspices of the

Department of Public Health.

However, the present need in Australia for the development of child guidance clinics is so great that clinics could be established by different departments according to their special needs without much danger of overlap. There is room for a number of clinics, both private and state controlled, provided that there is recognition of the difficulties, some of which have been reviewed in the foregoing discussion, and that these can be satisfactorily dealt with. There remains however the question of the integration of such services with the general programme of mental hygiene, integration which is easier to accomplish if the services are themselves well integrated within a department, rather than being under a variety of auspices. And this integration should ultimately go beyond the states to the country as a whole. In Australia, with its relatively small and homogeneous population, this should be not an impossible ideal.

### 4. Housing the Clinic.

Where and how a clinic is housed will depend on the controlling body, the specific purpose for which it is established, and local conditions. For example, a clinic associated with a hospital in all probability would be housed either in or adjacent to the hospital buildings as determined by the organization and plan of the hospital; a clinic to serve the school system would be situated where it could best meet the needs

of the schools. It is possible however to suggest a number of points which should be considered in housing a clinic, particularly if it is intended to serve the general community.

It is desirable that the clinic should be located as centrally as possible, and convenient to transport services - tram, bus and train - as parents will want to bring very young children for examination and perhaps for prolonged treatment. Since the clinic will serve a great many children from the lower income groups, it should be so situated that it is readily accessible to these groups. In cases requiring continued treatment, possibly with daily visits to the clinic, fares may represent a financial burden impossible for poor or unemployed parents to carry. Even though this expense could be provided for in the clinic budget, it is doubtful whether this is a practice to be encouraged. It is not merely that some people may take unfair advantage of such assistance; it is widely believed that in the interests of effective co-operation and treatment some effort and sacrifice on the part of the patient or parents is necessary. The clinic is not an agency for dispensing relief or charity and should not be so regarded. Although the clinic should be reasonably central and close to means of transport, it is preferable that it should not be in a busy street where all sorts of noises may interfere with testing and other work in the clinic requiring quiet. A quiet, restful atmosphere is indicated both for the sake of the clients and the staff.

The building itself should be attractive, well ventilated, well lit, warm in winter and cool in summer, presenting a pleasant and likable appearance to the child. A building that looks like a prison (as it may well have been), and that has a gloomy, official air about it, is likely to arouse immediately apprehension, distrust, and even fear in the child, who all too often has unhappy memories of buildings of similar appearance - courts, hospitals, institutions of one kind and another. Furnishings should be simple, strong and light, easily cleaned and not easily disfigured, such that a child in a destructive mood can do little damage to them.

The number and size of the rooms will depend on the actual organization of the clinic. Each worker must have a room where he can work in absolute privacy, free from interruption and other disturbances. In addition there must be a reception room, several play-rooms equipped to meet the needs of the age groups coming for service, toilets, and other rooms as needed for both staff and children. As additions to the staff are to be expected once the clinic becomes firmly established, suitable accommodation should be planned from the beginning. This is something to be remembered if one is dealing with government departments that are often loathe to plan for future development. If the clinic is going to maintain a training programme there will need to be facilities for conducting lectures, demonstrations, and rooms for student assistants and internes.

Many clinics overseas have been able to meet the require-

ments outlined above, not by building expensive and elaborate buildings, but simply by reconditioning and adapting private residences. Often a benefactor can be found who will be glad to turn over an old house, although unable to provide the money necessary for a new building. In any case, the cost of buying and reconditioning a private home may be cheaper than obtaining a convenient property and building on it. Moreover a private residence can be much easier and better adapted to the needs of a clinic than can most other kinds of buildings, such as offices, school rooms and the like. The location and general appearance of the private residence give a much more informal and friendly atmosphere than that of a more official type of building; and informality and friendliness are to be coveted by every clinic.

Of course a specially designed, modern building with all the latest in equipment would be delightful, but when this is not practicable, the making-over of a private residence as suggested above is an excellent substitute. But whatever provision is made for housing a clinic, it should permit of alterations, even change of the location of the clinic, according to the demands of changing conditions.

It is unnecessary to give a list of equipment for a clinic, as so much depends on the interests and needs of the individual clinic and its staff. However, it is not out of place to emphasize the need for a clinic to be adequately equipped before it begins its service. Inadequate, faulty and hastily

improvised equipment makes efficient functioning difficult, if not impossible. As much psychological material cannot be either made or bought in Australia, considerable difficulty and delay will be experienced in the purchase of new material or in the replacing of material damaged or lost. Accordingly, in planning a clinic generous allowance should be made for equipment, and the budget should permit not only the replacement of material, but also the acquiring of the new equipment and apparatus constantly being devised with the rapid advance that is taking place in psychiatry and psychology.

## 5. Summary.

In this chapter a brief review has been given of the historical development of child guidance as a method of providing expert assistance for children with emotional difficulties and problems of adjustment. Special reference was made to the Demonstration Clinics established in the United States by the National Committee for Mental Hygiene in behalf of the Commonwealth Fund, which resulted in an increased understanding of the objectives and techniques of child guidance. In comparison with the state of child guidance abroad, facilities for child guidance in Australia are extremely inadequate.

The philosophy of child guidance was seen as growing out of the developments in the three disciplines from which it draws its theories and techniques, namely psychiatry, psychology and psychiatric social work.

The child guidance clinic was defined as an agency for 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. The implications of this statement for the staff of the clinic in their relations with the child and the community were discussed. Stress was laid on the need for the clinic to maintain effective co-operation with other agencies working in the community, and on the need for the clinic to play a vital role in the general mental hygiene programme of the community.

The question of the various auspices under which clinics could be developed was dealt with under the broad headings of private and state control. Private clinics may have greater freedom than state clinics, but are liable to have considerable difficulty in obtaining sufficient and constant financial support. Public clinics maintained by the state, having greater economic security, can build up staffs in which team work, sustained research, and a high standard of service to the community are possible. Generally speaking the state-maintained clinic is to be preferred to the private one, though much will depend on local conditions. When the state is unwilling to provide clinics, it may be desirable for interested private individuals or groups to establish them.

The different government departments which could be considered as possible controlling bodies for a child guidance

programme were treated in turn: Education, Penal, Mental Hygiene, Children's Welfare, Public Health; and for convenience Universities were also discussed in this section. Advantages and disadvantages associated with control by these departments were indicated, but no absolute criteria were set up to decide which department is best fitted for the task. While the children in the schools, different state and private institutions, and in the community at large, are for the most part without child guidance facilities of any kind whatsoever, there is plenty of room for clinics conducted by more than one department, and under private as well as state auspices. It is essential that all child guidance clinics should be part of a general programme of mental hygiene, irrespective of the auspices under which they may be maintained. In Australia this mental hygiene programme should be on at least a state, if not a commonwealth basis.

In concluding this survey of the history, philosophy, and possible auspices of the child guidance clinic, some suggestions were made concerning the housing, location and equipment of the clinic.

## Bibliographical Note.

Most of the subject matter of this chapter is more fully discussed in two books to which reference has been made viz.

Stevenson, George S., and Smith, Geddes, Child Guidance Clinics, New York, The Commonwealth Fund, 1934.
Witmer, Helen Leland, Psychiatric Clinics For Children, New York, The Commonwealth Fund, 1940.

Other useful books are:

Institute for Juvenile Research, Chicago, Child guidance procedures, D. Appleton-Century Co., New York, 1937.

Rogers, C. R., The clinical treatment of the problem child, Houghton Mifflin Co., 1939.

## CHAPTER III

## THE STAFF AND ITS TRAINING.

### 1. The Clinical Unit.

As mentioned earlier, the staff of the child guidance clinic consists of a unit of psychiatrists, psychologists, and psychiatric social workers in the ratio of 1:1:2 or 3, with variations according to the particular needs and situation of the individual clinic. For example, a clinic working within a school system will in all probability have a greater percentage of educational problems than an outside clinic, and in consequence will require additional psychological staff, trained perhaps to deal with reading, speech and other difficulties of special importance to the school. In the absence of sufficient social service agencies in the community the clinic may have to perform duties usually done by such agencies, in which case extra social workers will be desirable.

When alteration in the accepted staff ratio is required in order to cope with prevailing local conditions, it is essential that care be taken to see that the peculiar function of the clinic is not obscured and its true perspective lost. This sense of perspective can be easily lost, if because of economy or some other reason, it is not possible for a clinic to employ full-time workers in each of the three fields mentioned. Because of the higher salary usually paid psychiatrists, sometimes the psychiatrist is only a part-time officer, even though theoretically he may be clinical director, with the result that decisions which he alone should make of necessity

may be made by other members of the staff, who occasionally will be found to be only too eager to assume added responsibility.

This raises the question as to who should be head of the clinic. Are we right in assuming that this office should fall to the psychiatrist? Though there is some disagreement on this point, the generally held view is that the psychiatrist is best fitted for the post. This does not imply that the psychiatrist is a superior person to the psychologist, or that he is more competent in every case to assume the responsibilities of directorship, as is sometimes felt by psychologists, and as psychiatrists themselves may sometimes hint. It is rather a matter of convenience. However democratic the organization of a clinic, some responsible head is necessary in order to represent the clinic in its outside relations, and to decide the many points of internal policy which call for immediate and authoritative decision. As many of the actions of a clinic relate to hospitals and the medical profession individually and as a whole, such contacts will be more likely satisfactory if they are made by a duly accredited member of the medical profession. In most cases involving serious personality disorders the diagnosis and prescription of treatment will ultimately fall on the psychiatrist, so it is desirable that he be the responsible officer. This is essential in the event of any dealings with the law, as when expert advice is sought by a court. In any case, generally speaking, the training and experience of the psychiatrist are more extensive than that of other members of the staff, and make him the obvious

choice for clinical director.

It must be born in mind that though one member of the staff has the status of director, the staff functions as a unit, a team. The choice of the professions to be represented in the clinic is the result of years of experience, and of a definite insight and philosophy growing out of that experience. The old concept of mono-causality has been rejected in favour of a field theory of multiple-causality of personality development and its disorders.[1] The understanding of any particular feature of personality (using this word in the widest possible sense) calls for the understanding of the whole person. It follows from this new concept, which alone is adequate, that it is not a matter of the three workers, the psychiatrist, psychologist and social worker, each going off on his own to study the case and then submitting his observations and results in order that a composite picture be gained of the individual. Each worker must see his position and the observations made in virtue of that position, as essentially integrated with that of the other workers, so that an understanding of the dynamics of the case is possible. Each must see the child as a person with a particular body-and-mind reacting in a certain way under certain conditions.

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1 This point is brought out by Dr. Lawson G. Lowrey in the discussion on "Trends in Therapy," American Journal of Orthopsychiatry, October 1939, pp. 689-690.

Hence the need of the clinical staff being a unit, a team, in which it will be difficult to clearly differentiate just where the field of one begins and ends. This is not to say that in many cases, both diagnosis and treatment will not clearly fall in one category more than an other, although even here caution is necessary. What may seem to the psychologist as nothing more than a reading difficulty may in fact require the investigation of both the psychiatrist and social worker. Consequently in the following discussion of the individual staff members of a clinic, it must be remembered throughout that we are dealing with them as members of a team, not simply as psychiatrists, psychologists and social workers. This organic approach makes the neat classification of duties, necessary skills and qualifications, somewhat arbitrary, but nevertheless a general outline can be attempted.

## 2. The Psychiatrist.

The duties of the psychiatrist come under two headings, administrative (assuming that he is clinical director) and clinical. As head of the clinic he or she will be responsible for the policy and conduct of the clinic. Often the clinical policy will be determined by the controlling authority under whose auspices the clinic operates, in which case, the director will be responsible for making such policy effective. This will involve the maintaining of cordial relations between the controlling body, the staff, and the public being served by the clinic, a difficult task for a director when there arises

a conflict of interests.

The director represents the clinic to the general public and relevant professional groups as may be required. This may mean sitting on various committees, taking part in community mental hygiene enterprises, giving addresses to interested societies and other groups, writing technical and popular articles for the general press and scientific journals, and countless other tasks associated with the furtherance of the objectives of the clinic as part of the mental hygiene programme of the community.

Within the clinic, the director is responsible for the efficient and harmonious functioning of the staff, for the provision of adequate equipment and facilities, and for the general well-being of all concerned in the work of the clinic. In most clinics, the director will be in charge of whatever training programme is carried on by the clinic, and for the initiation and oversight of research projects. Of course all the administrative responsibilities indicated above as falling within the province of the director need not actually be borne by him alone, as there can be a delegation of both responsibility and function.

In his capacity as psychiatrist, the director will have certain specific duties. The psychiatrist is responsible for the conducting of the general physical examinations, with special attention to pediatric and neurological aspects. The question of diagnosis and proposed treatment or other disposal of the case, and the communication of the clinical findings to

the parents or parties concerned with the child, generally rests with the psychiatrist. Where regular staff conferences are held, it is customary for the psychiatrist to preside. In cases requiring treatment of a psychiatric nature this is usually undertaken by the psychiatrist, although in some instances it may be delegated to either the psychologist or psychiatric social worker, the psychiatrist however being responsible for the general oversight of the treatment programme.

From this brief outline of the position of the psychiatrist it can be seen that the duties and responsibilities are very heavy, and in many cases too much for one man. Sometimes an attempt to lighten this load is made by the appointment of a pediatrician to conduct the medical examinations, and give the assistance which his special training makes possible. This is not usually a very successful arrangement. The overlap of the interests and qualifications of the psychiatrist and the pediatrician makes division of functions difficult, and tends to create duplication of activity, so complicating rather than simplifying the situation. Moreover, it is desirable that the psychiatrist himself conduct the physical examination, if he is to be responsible for the final diagnosis and perhaps treatment. In actual practice the pediatrician is apt to cease to be a pediatrician, and to become a psychiatrist, for which he may not have adequate training and experience.[2]

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[2] This question is discussed by Stevenson and Smith in the work referred to in the previous chapter, pages 115-117.

When administrative duties demand that the psychiatrist have an assistant, it seems that the appointment of an assistant psychiatrist is to be preferred to that of a pediatrician. This is likely to make for better co-operation and understanding within the clinical team. This arrangement is generally not only more efficient, but also more economical. A competent pediatrician would need to be paid a higher salary than an assistant psychiatrist. A system in use in clinics abroad and which could well be adopted in Australia, is that of appointing psychiatric interns or assistants in clinics, who thus gain valuable experience and in return for their training give the clinic their service at a much lower salary than that required by a fully-trained psychiatrist or pediatrician. In order that these internships should attract the right kind of candidates, it would be necessary that the clinic be recognized as a competent place for training, and that the conditions be at least as good as those offered by the general hospitals. Of course, there are disadvantages in the scheme from the point of view of the clinic, and an experienced psychiatrist would be preferred; but considering the difficulties in getting such a person at a salary a clinic in Australia probably would offer, the idea of internships has much in its favour.

What are the qualifications necessary for any one going into child guidance as a psychiatrist? This can be answered in terms applicable both to the senior psychiatrist and the assistant being trained with a view to later assuming full

clinical responsibility. In Australia, the primary requisite of course is an approved degree in medicine; and in addition, experience in the general practice of medicine in all its various departments, particularly pediatrics.

Dr. William Healy states in non-technical terms the following basic requirements for the physician going into child guidance:". . . training in principles of psychiatry, acquaintance at least with the concepts of psycho-analysis, training in making a good general and, especially, pediatric, examination. . . . Of course, we want a man, who, if possible, can make some contributions to the scientific advancement of our work; a man who can assume a certain amount of leadership in the community, perhaps do some teaching and speaking wherever he goes. . . We want a man who can take leadership with a staff of social workers and psychologists and possibly other psychiatrists and work well with them, but over and beyond that what we need is an individual who can get close to a youngster, child or adolescent, and have deep sympathetic understanding with him."[3] Dr. Healy is speaking here concerning the criteria for selecting candidates for training in child guidance, but his remarks, coming as they do from very extensive experience, clearly indicate the qualifications and

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[3] Symposium, "Objectives in training of psychiatrists," American Journal of Orthopsychiatry, 1940, 10, p. 3.

character essential for the psychiatrist functioning in a clinical unit.

Most authorities emphasize the importance of experience in adult psychiatry as gained in mental hospital internship, and there are good reasons why there can be no substitute for this experience. Actual contact with adult psychiatric patients, the end product in many cases of behaviour deviations seen in a children's clinic, will give the psychiatrist better understanding of the more serious disorders and their significance for the child. Frequently the psychiatrist in child guidance will find it necessary to treat either or both parents of the child if the child's problem is to be dealt with successfully, so that even in a children's clinic experience in adult psychiatry is extremely valuable. The great variety of conditions seen, the training in the different forms of therapy, the advantages of the contacts with other staff members, make mental hospital internship an indispensable part of the training of all desirous of specializing in child guidance psychiatry.

The value of the internship will depend on the nature of the hospital in which it is held. Dr. William A. Bryan states that the suitability of a hospital for intern training can be determined according to whether or not it is organized on five fundamental policies, as follows:

"1. The conception of psychiatry as concerned with those dynamic forces which affect personality rather than a classification of behaviour types or disease syndrome.

2. The practice of the highest type of medicine and surgery

as an aid to psychiatric understanding. The entire field of psychosomatic relationship well emphasized.

3. An educational program for training personnel in psychiatry. Students of all disciplines should be afforded the opportunity for such training.

4. A research attitude that expresses itself in the encouragement of attempts to study on a scientific basis the problems of psychiatry.

5. An acceptance of the responsibility the hospital owes to the community in the prevention of mental disease as evidenced by community clinics, both child and adult."[4]

A consideration of the implications of Bryan's demands for mental hospital administration, and a study of the manner in which he met them as superintendent of the Worcester State Hospital (U. S. A.), suggest that excellent though much of the work in Australian mental hospitals may be, from the standpoint of training they fall far short of the best available overseas. Consequently if mental hospitals are to give basic training for psychiatrists preparing for child guidance, considerable improvement in training methods and facilities is quite essential.

One further question concerning the training of psychiatrists remains. Should the psychiatrist be psycho-analysed? Probably child guidance more than any other branch of social science

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[4] Ibid, p. 5.

has been greatly influenced by psycho-analytic theory and technique. Thus in surveying the evolution and present status of therapy, Dr. Lawson Lowrey comments "That a psychoanalytic orientation regarding the origin of mental conflicts and associated anxieties, fears, and symptomatology in behaviour, is essential for therapy, whether it be direct or indirect, goes without saying."[5] It does not follow from Lowrey's statement that psycho-analysis is the therapy of choice for all child guidance cases, even if staff and time were sufficient for such a procedure. The percentage of children who need and can accept psycho-analytic treatment is certainly small, probably between five and ten per cent. If it is admitted that the orientation of the clinic should be psycho-analytic (and this is strongly disputed by some), first-hand acquaintance with psycho-analysis by the psychiatrist is desirable; if the psychiatrist is to employ psycho-analysis as a therapeutic method when necessary, then the psychiatrist should himself be analysed by an approved analyst. That an increasing number of psychiatrists and other clinical workers in England and America are being psycho-analysed as part of their training is testimony to the growing recognition of the value of psycho-analysis for all concerned with problems of behaviour in both children and adults. Even if one agrees that psycho-analysis is desirable, perhaps necessary, for all psychiatrists

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[5] Op. cit. (n. 1), p. 696.

engaged in child guidance, under existing conditions for many this will not be possible.

### 3. The Psychologist.

The function of the psychologist in the clinical unit is usually closely related to his training and previous experience. The psychologist is responsible for administering and interpreting the battery of psychological tests employed by the clinic; tests of intelligence, verbal and non-verbal, performance tests, tests of scholastic achievement, special aptitudes and vocational interests, of particular attitudes, of emotional adjustment and personality traits and organization. Not only will the psychologist be interested in tests for diagnostic purposes, he will also be concerned with research problems falling within his province, particularly the refining of existing techniques and the development and application of new ones.

Frequently the psychologist will have had experience in educational psychology and in teaching in a school system. This means that he will be the person best fitted for making contacts with, and suggestions to, school authorities, and being generally responsible for the strengthening of co-operation between the school and the clinic. In virtue of his training, the psychologist naturally will be the best person for dealing with problems definitely associated with schooling, reading and other scholastic disabilities. When a clinic has a great many cases of special disabilities such as in reading

and backwardness in certain subjects, it will be necessary to employ either part-time or full-time assistants competent to give the required special training or coaching. The psychologist has not the time for regular tutoring which could be done by less highly-trained people.

In the past, clinical psychologists have been employed mostly as psychometricians, but as the standard of training is improved, there is a growing tendency for them to move into the field of therapy. There is considerable theoretical justification for this. Whatever form of psychotherapy is used, much depends on rapport, the relationship established between the client and the therapist. Treatment begins the moment the client enters the clinic (if not before), and during the testing period the psychologist may develop rapport with the subject which would make him the appropriate worker to carry on the treatment. Provided that the psychologist has the necessary training and personal qualifications, and is working in a clinic in close co-operation with the psychiatrist and psychiatric social worker, there is no reason why he should not engage in therapy. It is impossible to state arbitrarily who should and who should not undertake therapy; much will depend on the qualifications of the different members of the clinical team, on the nature of the problem presented, and the actual case load already being carried by the various workers.

Like the psychiatrist, the psychologist may do a certain amount of training of students if the clinic maintains a

training programme. He may also have duties outside the clinic in connection with the community mental hygiene activities, involving lecturing, sitting on committees, and so on.

The question of the qualifications of the clinical psychologist is one that has been the subject of much discussion in both Great Britain and America. Probably there is no field so abused and open to quackery as that of applied psychology. Every daily paper will be found to contain advertisements of consulting psychologists, vocational guidance experts, psychotherapists of one kind and another, claiming to be able to settle people's problems about careers, marriage, business, anything and everything. Unfortunately, few of the people so advertising possess genuine credentials and qualifications for the service they advertise. The general public has no way of distinguishing the honest psychologist from the rogue. Australia, like most other countries, has a liberal share of psychological quacks, against whom the public has little or no protection.

In view of the unsatisfactoriness of the professional status of psychologists, attempts are being made to establish recognized standards for determining the competency of those wishing to engage in clinical and other forms of applied psychology. The ideal is that only those conforming to the prescribed standards should be permitted to practise any kind of professional psychology. In the United States, a committee appointed by New York City mental hygiene authorities published

what it considered to be the minimum requirements for clinical psychologists. As these standards are being widely accepted as a guide to thinking on this subject, it is worthwhile to print them in full here. Australia would do well to profit by the experience of workers over many years in this important matter.

"Recommendations for the training and experience of clinical psychologists.

It is recommended that there should be three ranks of clinical psychologists in a psychiatric clinic: (1) Junior Assistant Psychologist, (2) Assistant Psychologist, (3) Chief Psychologist.

A. Junior Assistant Psychologist.
The Junior Assistant Psychologist should have had one year of graduate study in psychology, equivalent to the requirements for the degree of M. A., including courses in abnormal psychology, psychological tests and measurements, statistics and laboratory training in the clinical use of tests. Candidates for this rank of psychologist must be skilful in the administration of standardized mental tests in common use in this work.

B. Assistant Psychologist.
The Assistant Psychologist should have had one full year of graduate study in psychology equivalent to the requirements for the degree of M. A. It is desirable that in addition to those listed above, the courses include educational psychology, remedial measures in educational disabilities and vocational counselling. He should have two years of full time clinical experience at the level of Junior Assistant Psychologist. This period should include experience with varied types of cases, such as pre-school groups, school children, adults, delinquents, behaviour problems, cases of school maladjustment, including remedial work, physically handicapped, cases with neurological involvements, mental defectives, psychotics, vocational problems, etc. At least one year shall be in a clinical organization involving work with psychiatrists and psychiatric social workers dealing with behaviour problems, personality maladjustment and related fields.

C. Chief Psychologist.

> The Chief Psychologist should have had two full years of graduate work in psychology. The Ph.D. degree, although desirable, is not essential. Emphasis should be more on specific training and experience since the degree in itself is no guarantee of adequate training in this field. The Chief Psychologist should have had at least five years of experience at the level of Junior Assistant and Assistant Psychologist, including experience with the different types of cases listed above. It is desirable that the experience of the Chief Psychologist include more than the minimum one year of joint work with other professional groups required by the Assistant rank. It is essential that the Chief Psychologist should have the ability to do and conduct research as demonstrated by completed research projects. The above are to be considered as minimal requirements. The specific requirements will naturally vary with the type of position."[6]

To some these basic requirements may seem a little too severe to be put into effect while training facilities are not sufficiently organized and standardized, but it must be remembered that the above standards are regarded by the expert committee drafting them as only minimal, that even higher standards are desirable and to be striven for if psychologists are to maintain professional status.

One feature not specifically mentioned in the above statement, and which has been stressed by some writers, is the desirability of experience in psychiatric hospital internship. Writing on this subject, Dr. David Shakow says that "there is a growing recognition of the need for an internship in the training of clinical psychologists", and he makes the comment that "the question might indeed be raised as to whether an

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[6] Standards of Training of Professional Personnel in Psychiatric Clinics. New York City Committee on Mental Hygiene of the State Charities Aid Association. 1935.

internship is not desirable for all psychologists and necessary for those who teach abnormal psychology."[7] The value of the psychiatric internship has already been discussed in reference to the psychiatrist, and the same arguments are applicable here. Other points which are emphasized by Shakow are that the internship "saturates the student with experience in the practical aspects of psychopathology", and it develops the "experimental-objective attitude." However, internship in a psychiatric hospital in which there are inadequate training facilities and insufficient supervision may be worse than no internship, if it develops attitudes inconsistent with child guidance principles.

If the psychologist is to engage in therapy, in addition to the requirements already mentioned training in therapeutic techniques is quite essential. This should include a careful study of psycho-analysis, and in the opinion of some authorities, a regular training analysis is desirable if not actually a definite requirement. No clinical psychologist, or for that matter no academic psychologist, is competent if he is not thoroughly conversant with the contributions of psycho-analysis.

It is necessary to stress the question of the required standards for clinical psychologists because not nearly enough attention has been directed to this matter. Even professional

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[7] Shakow, David. "An internship year for psychologists (with special reference to psychiatric hospitals)." Journal of Consulting Psychology, 1938, 2, May-June, 73.

people have assumed that because psychology is concerned with the problems of every day life, any one who has read a few books or taken some courses in psychology is competent to talk, write, and professionally practise psychology. As the foregoing discussion has tried to bring out, at least in the field of clinical psychology this is far from the case. The standards for the professional psychologist are as severe as those of any other reputable profession.

4. The Psychiatric Social Worker.

The inclusion in the clinical team of a social worker arose out of the need for a field worker, someone who would not be tied down to routine clinical work as was the case with the psychiatrist and psychologist. It was soon realized that a social history taken in the clinic often lacked the desired insights into the actual living conditions of the child. Particularly with delinquents it was felt that a first hand knowledge of the environmental and social situation was essential. So the social worker was engaged to gather the social history of cases being studied in the clinic. It was her duty to interview the parents and obtain as much family, social and personal data as possible; and as indicated to visit the home, perhaps interview other members in the family, to study the actual physical and social conditions of the neighbourhood, recreational facilities, the nature of the child's play companions, visit the school and contact the relevant teachers,

and generally make all the necessary contacts with people and agencies concerned in the case.

As a result of the investigations of the social worker and other members of the clinical staff, it was apparent that in many cases there were extremely unsatisfactory conditions existing in the child's immediate environment which needed to be altered or removed. Perhaps a child's sleeping arrangements were inadequate; lack of recreational opportunities associated with undesirable street companions may lead to delinquent conduct; the school may be exercising too much pressure on a dull child; the child may need a good holiday but the parents can't afford it; the parents and other members of the home group may display attitudes and behaviour prejudicial to the best interests of the child. These are instances of problems which the clinic had to deal with if treatment with the particular child were to be successful. As the social worker was responsible for investigating such situations, it fell naturally to her to make the required alterations and environmental manipulations, to conduct the social therapy.

The duties of the social worker were originally, and in many clinics still are, to obtain the social case history, and to conduct the needed environmental and social manipulations. Experience however has necessitated changes in this established plan of action for the social worker. Child guidance workers have realized that the older methods of systematically gathering all the available facts concerning the social situation

of the child are not what is wanted for an understanding of the child's problem. It is not the mere fact that the child's home has only four rooms which is important, but rather the meaning for the child of the attitudes and relations within the home, which of course may be due in part to the fact of there being only four rooms in a house accommodating a large family. The emphasis in working up a case history has moved from the routine collection of bare facts, to an understanding of the strains and stresses in the social situation, and the meaning for the child of the dynamic relations within the total social field of which he is part. Consequently, the social worker must have the training which will make it possible for her to approach the case study from this new point of view. The social worker in child guidance becomes a psychiatric social worker.

A further development is occurring with regard to the social therapy undertaken by the social worker. From the beginning, the clinic has had certain relations with the parents of children brought to the clinic for study and treatment. It was necessary to interview either or both parents to get the case history, to make suggestions concerning their attitudes toward the child, and to gain their co-operation in the treatment programme. Experience with children and their parents soon showed two things. In many cases, instead of being a problem child it was a problem parent; and in others it was impossible to gain the active co-operation of the

parent because personal factors made it difficult for the parent to accept and act on the advice given. Hence it is being realized that in nearly all cases of therapy with the child, therapy with either one or both parents is also helpful, if not actually more important than the treatment of the child.[8]

As the psychiatrist was traditionally in charge of the child as his "patient", and it was found inadvisable for him to maintain a therapeutic relationship with both the child and his parent, the social worker already having established rapport with the parent during the initial interviews was the obvious person to continue a therapeutic relationship with this parent. So by accident rather than design, and often without being fully aware of the situation, the social worker in addition to her other duties assumed that of therapist. This new situation was a difficult one to meet, for the social worker was not usually trained in therapeutic techniques, and in any case this was a novel therapeutic problem. It was necessary therefore to create new therapeutic procedures applicable to this specific relationship. Thus developed "relationship therapy", "passive" and "attitude" therapies.[9]

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[8] This change in emphasis is examined by Esther Heath, The approach to the parent: a study in social treatment; New York, Commonwealth Fund, 1933.

[9] Relationship therapy as a particular technique originated with the staff of the Pennsylvania School of Social Work. Passive therapy was not associated with any particular group, but was referred to by workers belonging to a number of different schools of thought. Attitude therapy was developed at the Institute for Child Guidance in New York City under the direction of Dr. David M. Levy.

These forms of therapy will be discussed in a later chapter. All that is necessary here is to point out that they are attempts to provide the social worker, without extensive training in psychiatry or psycho-analysis, with a reasonably safe therapeutic technique which will change the attitudes and relationships of the parent in a manner which will not only assist the parent's adjustment, but will also make possible successful therapy with the child. The whole question of the treatment of the parent is at present the subject of investigation and much debate. Although under the existing form of clinical organization the social worker can most conveniently work with the parent, frequently this is a more serious therapeutic problem than that of the child, and calls for psychiatric training not possessed by the social worker. In whatever way this matter is finally settled, the social worker, like the other staff members, will be involved in therapeutic relationships for which special training is needed.

What are the minimum qualifications demanded of psychiatric social workers who are to be competent for work in the child guidance clinic? The New York City committee which drew up standards for psychiatric clinical staffs, to which reference was made in the discussion of the qualifications of the psychologist, has also laid down the minimum requirements for the psychiatric social worker as follows:

"A. Assistant Psychiatric Social Worker.
1. Graduation from a college (i.e. university) of recognized standing.

2. Graduation from an accredited school of social work with at least 800 supervised field-work hours of experience in psychiatric agencies.
3. When there are two or more assistants in a clinic, at least one should have in addition to her educational background and training (as indicated in (1) and (2) above), a minimum of one year post-training experience under supervision.

B. Chief Psychiatric Social Worker.
In addition to the educational requirements for Assistant Psychiatric Social Worker, the Chief Psychiatric Social Worker should have had a minimum of three years post-training case-work practice, preferably with two of these years in a psychiatric clinic, and at least one year in a supervisory capacity." [10]

This means that the psychiatric social worker should have the B. A. degree or its equivalent, with courses in psychology, sociology, home economics, and similar subjects, and at least two years of study in social science, with courses in psychopathology, clinical psychology, behaviour problems in children, implications of mental testing, social case work, community organization, social legislation, and other kindred subjects.[11] The field-work should cover a wide range of social agencies, family welfare, hospitals, clinics, and other community organizations. For the social worker going into child guidance special emphasis naturally will be placed on experience in definitely psychiatric agencies, and on training in clinical procedures and therapeutic methods.

In addition to the academic and field experience qual-

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[10] Op. cit. (n. 6), p. 11.

[11] For a study of curricula in leading American schools of social work, see Lois Meredith French, Psychiatric Social Work, Commonwealth Fund, New York, 1940, chapter seven.

ifications the psychiatric social worker must have the right personality for her strenuous and difficult work. The psychiatric social worker needs to be emotionally mature and balanced, genuinely interested in people, sensitive to their needs and troubles, shock-proof and able to face disturbing situations without becoming disturbed herself, possessing tact and an attitude inspiring confidence and trust on the part of clients and others, and the ability to work harmoniously with the rest of the clinical staff. Good health is absolutely essential as the work is usually very strenuous, involving much physical and mental strain. Fortunately most, if not all, schools of social work pay close attention to the personality of applicants for training so that those with unsuitable personalities are unlikely to be able to obtain the recognized academic credentials.

It can be seen from this discussion of the role and training of the social worker that a tremendous change has taken place in the idea of the nature and function of the social worker and her duties. No longer is the social worker simply a well-meaning dispenser of charity, with a strong interest in other people's lives, often the result of inner conflicts and tensions. The modern social worker must be a highly trained, well adjusted individual, capable of specialized professional service.

### 5. Other Staff Members.

An integral part of the clinical team is the clinic

secretary. The clinic cannot function successfully if it lacks adequate secretarial assistance. The amount of work requiring secretarial attention is really remarkable, letters to be written, appointments made, telephones to answer, reports to be prepared, all of which would seriously affect the activities of the professional staff members if they had to deal with it. Probably there should be one full-time secretary to every four staff members, though this will vary from clinic to clinic.

There are a number of other workers who may be employed in the clinic. The bigger, well-established clinics in addition to the regular staff generally have research workers in the various aspects of the clinical service. Many research projects cannot possibly be carried by workers engaged in the full clinical routine, so that the employment of special research officers is necessary if valuable research is to be undertaken.

Mention has been made of possible psychiatric and pediatric assistance, and of people competent to give tutorial help in different subjects as required in cases of specific scholastic backwardness. Some clinics employ a speech therapist to deal with speech problems requiring direct remedial treatment. If the clinic play rooms are used for group play activities it is customary to have play room supervisors, who may be students in training. With the development of group therapy the role of the play room supervisor will become increasingly more

important, and will demand special qualifications not at present usually required.

Whatever additions are made to the basic clinical unit, the concept of the staff functioning as an integrated team, each member seeing his position and duties in reference to the whole, must be the dominating staff philosophy. Psychiatrists, psychologists, psychiatric social workers, research officers, secretaries and other assistants must work together as a co-operative unit.

# CHAPTER IV

## THE CLINIC IN ACTION.

### 1. Types of Service.

The nature and extent of the services undertaken by a child guidance clinic will depend on the orientation of the clinic to the community and the purpose for which it was established. A clinic connected with a juvenile court will function very differently from one connected with the school system. A new clinic which is exploring both its own possibilities and the needs of the community will probably take a greater range of cases and be more flexible in its policy than one which has arrived at a definite policy and programme. A clinic carrying a heavy training schedule may of necessity exercise a different criterion for case selection than one primarily concerned in providing a community clinical service. What a clinic does depends on its dominant purpose.

In general terms, however, it is possible to indicate the types of service given by most clinics.[1] Although there are slight differences in nomenclature, the following classification covers the various kinds of service whatever they may be called:

1. Full Clinical Service.

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[1] For a discussion of the classification of clinic services see: Mary Augusta Clark, Recording and reporting for child guidance clinics, Commonwealth Fund, New York, 1930.

A complete study is conducted, including social history, physical, psychiatric and psychological examinations, a diagnosis is made and treatment prescribed and carried out by the clinical staff. When this service is given with the co-operation of another agency, it is usually referred to as co-operative full service.

ii. Diagnostic Service.

A full clinical study is made and the necessary treatment decided upon, but responsibility for the treatment does not rest with the clinic which makes recommendations to the referring body, the parents, school, court, as the case may be. If this is done in co-operation with some other agency, it is known as co-operative diagnostic service.

iii. Special Service.

In this instance a full study is not made of the case, only a limited service is necessary, and the appropriate report and recommendations are given. This also may be done in co-operation with another agency.

iv. Consultation Service.

This consists in interviewing children, parents, staffs of other agencies, giving information and advice as indicated.

v. Educational Services.

The activities of the clinical staff outside the clinic which are concerned with the education of the community in the principles and ideals of mental hygiene.

vi. Staff Training.

The conducting by the clinical staff of lectures, demonstrations of clinical methods, and case conferences for the benefit of students and professional workers.

For convenience, the first four of these services will be discussed together, and then the last two, under the headings clinical and educational services respectively.

2. Clinical Services.

An extremely difficult question for any clinic to decide is how the clinical case load should be divided amongst the various kinds of service so as to give the maximum benefit to the community. To strike the happy balance between the quantity and quality of the service is not easy. Is it better to give a full, thorough study and treatment to a few cases, or to give a partial, superficial service to a great number of cases? A heavy case load looks much more impressive than the much smaller case load necessary if many are to be given full clinical service. Experience has clearly shown that there are many more children in need of assistance than clinics as organized at present can possibly deal with, and that many of these children can only be helped by full study and treatment.

How the dilemma is attacked will vary according to the size and training of the clinical staff, and the actual demands of the particular situation. The Bureau of Child Guidance, City of New York, reported that for the five year period,

1932-1937, slightly over 25 per cent of the 7,511 children examined were given full clinical study and treatment.[2] According to the report, this proportion allocated for full study represents the maximum amount of service that is consistent with good quality. What this service means to the clinic, and the value of it to the community can be seen from the figures given in the report. An analysis of 100 full service clinic cases revealed that the average duration of treatment was 13.92 months; while of all cases given full service, 80.5 per cent resulted in improved or satisfactory adjustment, only 19.5 per cent showing no improvement.

Full Clinical Service.

In the full clinical study all the resources of the clinic are brought to bear on the case. The psychiatric social worker investigates the home, school, social and environmental conditions and their meaning for the child, obtains the complete family history and the developmental data concerning the child from the pre-natal state up to the present. The psychologist conducts the various psychological tests indicated by the nature of the problem presented, and interprets the test results relative to the individual child. The test battery usually contains standard tests of intelligence, verbal and performance, of educational achievement, and of personality,

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[2] Five Year Report, 1932-1937, Bureau of Child Guidance, Board of Education of the City of New York.

other tests being given as required. The psychiatrist makes a thorough physical and psychiatric examination, paying special attention to the medical history of both the family and the child. When special investigations are needed for which the clinic may not be equipped, such as X-ray or electro-encephalographic studies, the psychiatrist will have to make use of consultant or hospital services as available.

For the convenience of the workers concerned with the case, and in the interests of staff training and possible research projects, it is essential that complete and systematic records be taken. How to combine conciseness with comprehensiveness and uniformity of method without losing the peculiar characteristics of the individual case, are constant worries of many clinic workers.[3]

When the various investigations are completed a case conference is held, generally under the direction of the psychiatrist, attended by all the workers concerned in the case. When the clinic is co-operating with other agencies in a particular case, it is important that these agencies should be appropriately represented at the initial and any subsequent conferences. At the case conference the case is discussed and in the light of all the available data a diagnosis, which may be only provisional, is made, and the form and means of treatment decided upon. If necessary, during treatment further

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[3] Case recording is dealt with by Mary Augusta Clark, op. cit. (n. 1).

case conferences may be held, and perhaps a final conference when the case is being closed. In small clinics not having students in training these case conferences are sometimes quite informal, but in bigger clinics in which students are being trained case conferences are usually conducted regularly and systematically, and are more formal.

The type of case requiring full clinical service, and the nature of some of the difficulties encountered can be seen from the following cases studied by the writer. For the sake of brevity, only very limited and incomplete abstracts are given.

The case of Fred.

Fred was a nine year old boy brought to the clinic by his mother because she was anxious about certain fears the boy had developed, and because his general health was suffering from eating and sleeping difficulties. It appeared that he was afraid of goind crazy, of choking to death during frequent stomach cramps and choking fits, of getting lockjaw from imaginary scratches, of being poisoned by everything he ate - hence the eating difficulties - and constantly afraid that if his mother left him alone something might happen to him. His sleep was disturbed, he dreamt of ghosts, and had nightmares. Obviously a case in need of immediate and full study.

A study of the family and home situation revealed a number of unhealthy, prejudicial factors. The father was opposed to the mother referring Fred to the clinic and refused to cooperate or to be interviewed. He was an unemployed butcher with poor prospects for obtaining permanent employment. According to the mother, some years before they married, he had a "nervous breakdown", and another attack when Fred was two years old. This second illness was apparently characterized by chronic vomiting, ideas of reference and persecution, and violent conduct necessitating his removal to a psychiatric hospital from which he was discharged after three months. Since then he has been morose, irritable, hypochondriacal. Nothing was known by the mother concerning his family history.

The mother, a kindly, tired, anxious looking woman in her late thirties had never known security. She was two months old and the youngest of three children when her mother died, her

father remarrying and having two more children. She was unhappy and felt inferior as a child, and this led her she thought to make an unwise and sudden choice of a husband. Though fond of children, because of difficulties in labour, she had terminated her third pregnancy in self-induced miscarriage. She did not want Fred, but her husband insisted on her having another baby. When he was born she felt that she had neglected him because at that time the eldest child was seriously ill. Then when he was two, the mother could not give him sufficient attention because of the mental condition of the father. She seemed genuinely fond of Fred, and was very worried lest he should become like his father, for which she felt she would be to blame. Though greatly disturbed by the situation, she displayed a good deal of insight and understanding, being anxious to do everything in her power for Fred.

The siblings were a sister, sixteen, who was ill with pneumonia and scarlet fever when Fred was a baby, and though sickly as a child had grown into a strong well-adjusted girl. A brother, aged thirteen, also had had a record of sickness and still was below average physically. The mother said he was secretive, difficult for her to understand. He was a good pal to Fred, though lately had become rather critical of him.

The family was Jewish, Yiddish being spoken in the home. The neighbourhood was a near-slum district, the family living in a three room apartment. The father and mother slept on a couch in the living room, the three children sleeping in the bed room, Fred and his brother sharing a bed.

Fred was a "cranky baby" according to his mother, crying for hours and vomiting when given food. At this period the mother says she neglected him because of his sister's serious illness. He had measles at two year; chicken pox at two and a half; mumps at seven; tonsils and adenoids removed at seven, for which he was not prepared and which was a terrifying experience for him; cut his hand at eight, and had three stitches which further frightened him; this was followed with scarlet fever. Six months before coming to the clinic he had been receiving injections for anemia, but this had to be discontinued when the father lost his job. When examined in the clinic, he was pale, thin, undernourished, ten pounds underweight, with secondary anemia. He was extremely scared of the doctor.

Toilet training was satisfactory, though enuresis still persisted. He masturbated at two and a half, but discontinued when told to by his mother. However she had noticed sex play between Fred and his brother and other boys. When he was five, he asked about babies and was told that they came as

a result of the food the mother ate. In spiteful moments the father had told him about his mother's miscarriage and that he hadn't been wanted either. This always upset him considerably and he would seek constant reassurance from his mother that she did really love him. The troubles for which he was brought to the clinic had developed three months previously.

The school report showed satisfactory school progress and adjustment, until the appearance of the fears mentioned. He became inattentive, day dreaming, restless, afraid to go to school. At the clinic he appeared excessively shy, timid, uncommunicative, strongly inhibited, extremely attached to his mother, adopting a passive attitude both to her and the clinic staff. The Stanford-Binet I. Q. was 98. The Rorschach and Murray tests showed marked anxiety, constriction, and repressed aggression.

Here was a boy, living in an unsatisfactory home; with a father who was a failure as a man and father and exercising a decidely unhealthy influence; an anxious insecure mother with strong guilt feelings concerning her treatment of the boy; a bad medical and developmental history providing some grounds for the fears which had developed. In this insecure and disturbing home situation the boy felt rejected and afraid that even his present security was in danger. His symptoms were at least in part a protective device as well as a means of expressing his repressed aggressions.

Although this may seem a particularly complicated and difficult case, its complexity and difficulty can be paralleled and even exceeded by scores of cases in the files of any child guidance clinic.[4] It shows very clearly the necessity for a

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[4] For a detailed presentation of some child guidance cases see: Child guidance cases. Edited by Mary B. Sayles. Commonwealth Fund, New York, 1932, 608 pages. This book presents practically in full eight case records selected from various clinics. The cases provide material for discussion of personality problems, the gathering, recording and evaluating of information about the child and his background, the conducting of interviews, and treatment procedures.

full study from the social, psychological, psychiatric and physical points of view; without any one of them a true picture of the condition would be quite impossible. This case also demonstrates how useless it would be to single out any one single factor as a cause of the boy's condition and which should therefore be treated. Actually this case required the attention of all three workers, the psychiatric social worker, psychologist and psychiatrist. Alterations had to be made in the living conditions of the family and arrangements made to make it possible for a more adequate family diet, particularly more milk. It was necessary to work with the mother, to give her better insight into her own problems and anxieties, and to help her gain the assurance and security she needed. Unfortunately nothing could be done with the father, who in any case was probably a serious psychiatric problem. The boy's physical condition needed immediate attention, and his mental state demanded expert psychotherapy. Moreover each one of these factors could only be satisfactorily understood and dealt with when they were seen in terms of the dynamics of the total situation.

One further case will be cited to illustrate further the points that have been made concerning full clinical service. The case of Maurice.

The trouble with Maurice was that he was a "thoroughly naughty boy", responsible for constant mischief and devilry at home and in school. He was restless, hyper-active, rude to parents and teachers, deliberately destructive, unresponsive to the threats, punishments and pleadings of his parents. Having

reached the limits of their endurance the parents brought the boy to the clinic.

When this ten year old lad was examined in the clinic, he appeared to be a healthy, alert, energetic boy of superior intelligence, with no indications of any abnormalities. But behind his angelic appearance there was something quite different. The school reported that he was erratic and careless in his work, restless, a trouble-maker, and a source of worry to the teacher, who with a class of 40 children was compelled to use repressive measures with Maurice for the sake of order and discipline. The leader of a play group to which he belonged reported that it was only as a great favour to the parents that he kept the boy in the group, so troublesome and disorganizing was his conduct.

The significant features of this case were to be found in the family situation. Maurice was the only child of middle class parents in their late forties. The father had conducted a perfumery business, but owing to an unspecified heart condition had to give up work and stay at home while his wife carried on the business. Thus the usual parental roles were reversed. From the age of five till fifteen the father had lived in a large orphanage run on lines of rigid, harsh discipline. He displayed extremely obsessional attitudes towards the boy, and was unconsciously demanding from him the sort of behaviour that had been demanded of himself. The family lived in a four room apartment, so that father and son were necessarily together outside school hours. Literally everything the boy did was supervised by the forever moralizing, fussy, overscrupulous and neurotic father. Although the father repeatedly insisted that he was guilty for the boy's misconduct, yet he was always careful to attribute the blame for any particular incident to his wife or the boy.

The mother was feeling the strain of her business life, and appeared to harbor some resentment at being forced to work while her husband stayed at home, though consciously she accepted it as unavoidable. The parents disagreed frequently on how to deal with Maurice, and would argue heatedly, resulting in the husband retiring to bed with a "heart attack." The attitude of the parents to the boy was characterized by inconsistency and uncertainty. The father would lecture him and threaten punishment which would never be given, the mother cajole and take sides against her husband.

Maurice was a healthy, very active youngster who had the misfortune to have to spend most of his time with a rigid, obsessional father, with limited opportunities for free and vigorous play necessary at this age. In a home with tension ever present between the parents, it was easy for an intelligent boy to express the inevitable aggressions he had against

his father by means of disobedience and similar ways of behaving, confident that because of his parents' inconsistency and disagreements he would always triumph over them. This behaviour carried over into other situations such as the school, where through lack of understanding attitudes were displayed which merely served to strengthen the boy's perverseness.

This case illustrates the influence of some of the social factors discussed in chapter one. The family with one child, living in the big city in an apartment which does not permit sufficient freedom and leads to tensions in the family. The reversal of the parental roles, and uncertainty and inconsistency in the attitudes operative within the domestic situation contribute to the development of behaviour problems in the child. Like the previous case, this one called for a full clinical service and required treatment applicable to the total situation. It was necessary that some one work with the father in order to give him insight into his own behaviour and attitudes, so that he would release some of the pressures he was exerting on the boy. The mother was in need of help in adjusting to the conduct of both her husband and son. Both parents needed definite guidance in directing the general home situation. The school had to be led to an understanding of the problem so that it could pursue a different policy with regard to the boy's school behaviour. Then treatment of the boy was necessary if the conduct patterns so firmly established were to be changed. Again we see the importance of considering the problem presented against the total social field of which the particular boy was a part, and in terms of this work-

ing out the treatment programme.

Other types of problems for which full clinical study may be sought are those characterized by such symptoms as excessive day-dreaming, truancy, stealing, sex delinquencies, temper tantrums, enuresis, negativism, lying, school failure, "nervousness".[5] Though clinic annual reports often classify cases according to various categories such as problems associated with conduct, personality and habits, or perhaps according to the severity of the condition treated or the causative factors, all such classifications are quite arbitrary. Actually there are usually a number of symptoms present in any one case, and it is impossible to rank them in order of importance for all are essential aspects of the complete clinical picture. As there is no one to one relationship between a specific "causative factor" and the behaviour to be studied, any table of problems in terms of causative factors is necessarily a clinical artefact. Classifications of symptoms presented in clinical studies and of so called causative factors are useful only as a means of indicating the wide range of behaviour disturbances dealt with, and of the presence in the lives of these cases of certain unhealthy influences which have contributed to the development of the particular difficulty.

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[5] These problems are discussed in a great many books on child psychiatry and clinical psychology such as:
Kanner, Leo, Child psychiatry, Charles C. Thomas, Springfield, Ill., U. S. A., 1935.
Louttit, C. M., Clinical psychology, Harper & Brothers, 1936.
Moodie, William, The doctor and the difficult child, Commonwealth Fund, 1940.

Diagnostic Service.

As pointed out earlier, in the diagnostic service a full clinical study is made but the clinic does not carry out the treatment, instead it makes recommendations to the agency which has asked for the diagnostic study. Sometimes a case referred merely for diagnostic service may be taken on for treatment as well, and sometimes one referred for full clinical service may only need the diagnostic study or else the clinic finds it impossible to undertake treatment. Since the procedure for diagnostic service as far as the initial study is concerned is the same as that for full clinical study, it is not necessary to repeat the discussion here.

This type of service is often undertaken for children's courts and schools that do not have the staff necessary for making a full study of problem children with whom they have to deal. When separate facilities do not exist for the diagnosis of mentally retarded and defective children a major part of the clinic's diagnostic work may be with such cases. Some people are of the opinion that the problems of mental deficiency and behaviour disorders should not be dealt with in the same clinic, and for this there is considerable justification.

As Stevenson and Smith point out there is danger in the clinic so greatly extending its services that it may fall below the possible maximum efficiency.[6] Unless care is taken, a

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[6] Stevenson, George S., & Smith, Geddes, Child guidance clinics, Commonwealth Fund, 1934, p. 72.

clinic can become so crowded with cases of mental deficiency, epilepsy, and neurological handicaps, that its real function of dealing with children with behaviour difficulties amenable to treatment may be seriously weakened. Usually the diagnosis of such conditions as those just mentioned does not require the full case study discussed above, and could be done by agencies specializing in such work, rather than by the child guidance clinic which generally faces a far greater demand for service than can be met.

Special Service.

Frequently children are referred to a clinic for examination and advice on one particular feature not necessitating a full diagnostic study. The problem may be backwardness in a certain school subject, vocational guidance, uncertainty concerning the child's ability for advanced school work, and the like.

The case of Mary.

Mary was fourteen years of age and had just completed the eighth grade in the elementary school. Her school record showed that with difficulty she had been passing her examinations, and it seemed as if she was reaching her school limit. Her parents were anxious for her to go on to high school, but she was keen to go to technical school and learn dressmaking.

The school reported that she was a conscientious worker, but rather slow and weak in academic subjects while doing well in drawing and craft work. The psychological examination showed that she was of average intelligence, with a tendency to do better on performance items than verbal ones. Educational tests confirmed the results given in the school record. A vocational interest test indicated that dressmaking and similar occupations were those most congenial to her.

In the light of the test results it was possible to convince the parents that it would be best if the girl were allowed to follow her interest in dressmaking, for which she showed indications of the necessary ability, rather than compel her to go on with academic training in which she had little chance of success. Information was given concerning possible schools and courses that might be taken. Both Mary and her parents were satisfied that a right decision had been made and that a successful adjustment would be made to the new situation.

This is a simple case, no intensive study being made and no profound advice being given, but without the help of the clinic a girl would have been forced into work for which she lacked the necessary interest and ability, which might easily have led to a serious problem later on. Herein lies the value of much of the less spectacular work of the clinic. Advice and information given at the right time will prevent the development of many problems of a really serious nature. After all child guidance should be concerned with guiding children and their parents so that the number of cases requiring deep therapy will be greatly reduced if not actually eliminated.

Consultation Service.

Once a clinic becomes well established it will serve as a centre for advice and information on all sorts of questions. Contacts will be made by telephone, letter and personal application by parents and others desiring information on educational and mental hygiene matters. A parent may want to know about institutional care for an epileptic child; another will want advice about literature dealing with sex education

of children; someone else will seek information concerning holiday camps or recreation groups during the school long vacation. A teacher may want advice on a particular school problem; a clergyman may be worried about certain unhealthy influences in his parish; a scoutmaster may be experiencing difficulties with some boys in his scout troop. Sometimes people will come to the clinic with problems and questions, trivial and serious, because they are uncertain where to turn for the proper assistance.

In some of these cases the clinic will be able to give the assistance sought, in others it will steer the enquirer to the appropriate agency. Although this is a time consuming business, it represents a real community service. The Judge Baker Guidance Centre, Boston, in one year steered 3500 cases seeking assistance to the proper agencies - hospitals, clinics, physicians, schools and other institutions.[7] This demonstrates how useful to the community such service can be and the need for the clinic to have information on other agencies and services readily available.

From this brief glimpse at the clinical activities of the child guidance clinic some idea can be gained of the extent and nature of the problems in the community which can only be satisfactorily dealt with by expert workers, such as found in the modern child guidance clinic. It can also be

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[7] Judge Baker Guidance Centre, Annual Report, 1939, Boston, U. S. A.

seen that no clinic could function properly without a full staff of psychiatrists, psychologists, and psychiatric social workers, co-operating as a clinical unit.

### 3. Educational Services.

In addition to its strictly clinical activities a child guidance clinic usually undertakes certain educational services. As was pointed out in chapter II., the clinic has a definite place in the general mental hygiene programme of the community, and the success of the clinic will be determined not merely according to how effectively it discharges its clinical duties, but also according to its effectiveness in spreading the principles of mental hygiene. Herein lies its first educational responsibility.

It must be emphasized that the provision of clinics cannot be a substitute for the education of the whole community in mental hygiene. Even if sufficient clinics could be established to treat all the children requiring clinical service, at present a remote ideal, without the enlightened co-operation of the community much of the work of the clinic will be ineffective. Not only must the community be educated concerning the work of the clinic, to proper use of it and willingly to co-operate with the clinic staff in its endeavours, it must also be educated in the fundamentals of individual and community mental hygiene. If the thesis being maintained here be true, that many of the problems dealt with in clinics are

the result of social disorganization and prevailing social attitudes, then the logical thing to do is to improve the organization of society and change undesirable social attitudes. Child guidance clinics, as clinics, are really engaged in ambulance work, picking up children who have fallen out in the struggle of life, and giving them first aid. This is necessary and extremely valuable, but the ideal of the clinic should be to make its job unnecessary. Consequently the clinic must be interested in the promulgation of facts and principles essential for mental health and successful adjustment by children and adults amidst all the confusion of constant social change.

The extent and form of the educational activities of a clinic and of its individual staff members will depend on the needs and opportunities existing in the particular community. Reference has already been made in chapter III as to how the psychiatrist and psychologist might serve the community outside their clinical duties, and what has been said applies also to other members of the clinic staff. Of course such activities as may be engaged in outside the clinic should be such that they will not interfere with the proper functioning of the clinic itself.

An important aspect of the educational work of a clinic is its influence on the thinking of professional groups coming in direct contact with the clinic during work with individual cases. Thus teachers, probation officers of children's courts, judges, social workers, physicians, and other pro-

fessional people collaborating with the clinic will gain some insight into the procedures and principles employed by the clinic, which may seem quite commonplace matters to the clinic staff, but may be revolutionary ideas to those not actively engaged in child guidance. In this connection some clinics have employed the method of open case conferences, the usual clinic conference on a case being open not only to the parents and the workers actually interested in the case, but also open to any professional people interested in learning about child guidance principles and their application. Although this method has been employed with considerable success in certain instances, as for example by Dr. Ira S. Wile at Mount Sinai Hospital, New York, generally speaking it has not found much support amongst clinic workers. The open case conference tends to be a little confusing to visitors who are not familiar with the techniques used, and who can only be given a complete understanding of the case at the expense of the time of the staff involved in the particular conference. In the open case conference there is a danger that confidences given to the staff by clients may unintentionally be violated, and yet if the conference is to be worthwhile it must be possible for the staff to discuss the case with all frankness. But whether or not the open case conference is used, every opportunity for the staff to educate outside workers should be accepted and used as profitably as possible.

Apart from contacts with other professional workers in

the course of ordinary clinic activity, the staff will exercise an educational influence in the different professions to which they belong - medicine, psychology and social work. At professional conferences, meetings and on other social occasions, and through the medium of professional journals, the staff of the child guidance clinic will be contributing to education in mental hygiene of the various professional groups.

Many clinics conduct organized training for workers in the three fields of psychiatry, clinical psychology and psychiatric social work. For work of such a directly educational nature the clinic must be well established and sufficiently staffed so that this will not interfere with more urgent clinical problems. It is usual for this staff training to be done in co-operation with the relevant professional training schools in the community, medical schools, university psychology departments, schools of social work, or whatever institutions may be responsible for professional training. The clinic may conduct lecture courses in the different fields, either at the clinic or within the institutions concerned, at both the undergraduate and graduate levels. Provision may also be made for training fellowships, assistantships and internships, which permit of active participation in the entire clinical programme. If child guidance is to be developed according to the tremendous needs at present existing, it is of paramount importance that those desiring to qualify for the work should have opportunities for training which cannot

be obtained anywhere else but in child guidance clinics.

Thus besides a heavy and varied clinical programme, the clinic staff are faced with both lay and professional educational needs in mental hygiene and child guidance, duties which demand the high standards for clinic personnel reviewed in the preceding chapter.

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# CHAPTER V

## DIAGNOSTIC METHODS.

### 1. The Approach to the Case.

During the early days of its development when it was strongly influenced by traditional psychiatry and clinical medicine child guidance theory clearly distinguished between the diagnostic study and the treatment programme. It was customary to complete as far as possible the full case study, make a diagnosis, and then plan treatment according to the diagnosis. Clinicians thought in terms of a distinct dichotomy of diagnosis and treatment. Although this dichotomy could be maintained in theory, it was soon discovered that in actual practice this was often quite impossible. With the development and extension of the nature of the full case study, in many instances it was necessary to initiate therapeutic action before the full study was completed, and study and treatment would then proceed together. Moreover with the general reaction against the practice of pinning neat clinical labels on cases, and the difficulty very often of making anything but a provisional diagnosis and prognosis, the distinction between the diagnostic and therapeutic periods naturally became somewhat artificial. Besides, as clinicians critically analyzed their procedures they began to realize that treatment commenced as soon as a relationship was established between the clinic and the client, that during the diagnostic investigations attitudes were developed which were most important for the therapeutic programme which was to

follow the study.

Thus in both theory and practice the tendency to draw sharp lines between the diagnostic study and therapy has almost disappeared from many of the better clinics. On the whole this is a thoroughly desirable advance in child guidance thinking, emphasizing as it does the need for continuity and integration in the relations of the clinic with the child. If treatment begins with the first contact of the clinic with the child and his parents, then no longer can the child be treated during diagnostic study as a human guinea pig to be subjected to a great variety of clinical tests and experiments, before being handed over by the investigator to someone else to carry out the necessary therapy.

This new approach can however be carried to the extreme of neglecting adequate diagnostic examination, which is perhaps worse than laying too much stress on diagnostics. Some clinics in discarding the traditional stereotyped diagnostic procedures have discarded routine psychiatric and psychological examinations altogether, the attitude being that these are conducted as indicated during the progress of therapy. This may result in therapy being undertaken without clear objectives and in ignorance of data basic for the understanding of the case on which sound therapy must be built.

It is true that there is considerable overlap of the diagnostic study and treatment, that in the early stages of child-clinic relations they may go along together and continue

to influence each other, but to confuse the two is a serious mistake. A properly conducted diagnostic study is essential if the appropriate treatment programme is to be planned and carried through with the maximum of efficiency and without loss of valuable time. For example, it would be silly to attempt to treat psychotherapeutically a boy who has been playing truant from school and acting very aggressively while in school, if, because a thorough physical examination was neglected the fact that he has a hearing defect is not known by the therapist. This single fact may throw entirely new light on the case. Unless the clinician is fully aware of the social situation of the child, it may be positively harmful for him to suggest certain changes in the home. Yet these mistakes are sometimes made in clinics in which systematic routine diagnostic studies are not made the basis for treatment.

The nature of the diagnostic study was discussed in the preceding chapter. It was seen to consist of the social study and the developmental history, the psychiatric and physical examination, and the psychological investigation, all of which consider various aspects of the child as a growing, adjusting, integrated human organism. Considerable attention is usually devoted to the early life and development of the child, a fact which has been responsible for much confusion in diagnostic theory. While psychological theory was dominated by the concept of causation as historically determined, a position still held by some schools of thought, for example psycho-

analysis, it was believed that the actual causes of a particular form of behaviour were to be found in the early life experiences of the child. Hence the case history was of first importance for the discovery of the causative factors requiring to be dealt with.

With the increasing influence of modern field theory in psychology and in all the other sciences, the old view of causation is no longer tenable. Causation is a-historical, it is to be found in the present total situation and not in the past as such. If one knew all the factors operating in a situation and had the necessary insight into the existing dynamics of the personality in question, it would be possible to understand completely the behaviour of the person, to make an accurate diagnosis, without recourse to the past life of the individual. But as such insight and knowledge are rarely possible, if ever, the case history is an indispensable aid to an understanding of the present condition of the individual.

This point of view is emphasized by Virginia P. Robinson in A Changing Psychology in Social Case Work as follows: "It seems to me we are struggling in a confusion between knowledge of the present situation which carries necessary diagnostic and prognostic value and history of the individual's past which has value in building up our general understanding of conditioning experience but carries no meaning for treatment in the present problem. . . If and when we accept this distinction, we shall be concerned, in the early contacts, with

obtaining as full and complete knowledge as possible of the present situation of each individual in his relationships with all the elements in his environment which have emotional significance for him. . . If this distinction is accepted, history will not be needed to bulwark our uncertainty or to substitute for our ignorance of present reactions. History will take its place in the relationship not in terms of the case worker's need but as one of the clients reactions."[1] History taking then is necessary as an aid to understanding the case, but strictly speaking diagnosis cannot be made on the basis of the case history, for valid diagnosis rests on insight into the present life situation of the patient.

The details and method of the physical and psychiatric examination cannot be stated dogmatically as there is no one standardized procedure, the actual extent of the examination being left to the discretion of the psychiatrist who will decide according to the nature of the problem what special studies are indicated. This does not sanction, however, haphazard examinations and unsystematic recording, for in the interests of careful diagnosis, for the information of other members of the staff working with the case, and for the sake of research projects which at the time of the particular

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1 Robinson, Virginia P, A changing psychology in social case work, University of North Carolina Press, Chapel Hill, 1934, pp. 140, 143.

examination may not be foreseen, it is essential that each clinic follow some definite system in the conducting and recording of all examinations and investigations.

Here we are more particularly concerned with the techniques to be employed in the psychological examination, testing devices generally grouped together under the heading of psychometrics. Because psychologists have felt that if psychology were to win recognition as a science it must be able to make measurements as in the physical sciences, literally thousands of instruments have been devised to measure every conceivable aspect of the human organism - intelligence, performance ability, educational achievement, manual dexterity, vocational interests, attitudes, personality traits and types, physiological reactions, and much else besides. Although many of the claims made for various psychometric instruments were ill-founded and much too ambitious, psychometrics has made an extremely significant contribution to clinical diagnostics. Before considering some of the most useful psychological tests, some general comments on the value and the weaknesses of such tests are necessary.[2] First let us look at the value of clinical tests.

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[2] The writer is following here a discussion of psychometrics in chapter 3 of C. M. Louttit's book; Clinical psychology, Harper & Brothers, New York, 1936.

i. The best tests or parts of them represent under controlled conditions situations corresponding to those in everyday life. Thus it is to be expected that the child who is unable to observe simple directions, to distinguish obvious differences in forms, to calculate easy problems in giving change, will have serious difficulties in normal social situations where skill in these matters is necessary. What the child can and cannot do in a test usually will reveal a good deal about the actual social adjustment of that child.

ii. A test such as the Terman-Merrill (Stanford-Binet) intelligence test is much more than a mere measuring device giving an I. Q. level, it is also a form of interview revealing certain attitudes, behaviours, and information about the child. The test behaviour of the child often is much more significant than any score obtained on a test. Does the child behave with confidence or anxiety; does failure lead to a temper tantrum or renewed effort; is the child co-operative or negativistic? The responses of the child to the test questions are not something to be mechanically scored and then forgotten for they may give valuable insights into attitudes and feelings not otherwise expressed. To interpret any test simply in terms of the score obtained is not only to neglect valuable material, it is to risk grave errors in interpretation.

iii. The standardization of tests makes possible the comparison of the test results of a child with those of other children of the same age, sex, social status, school level,

as the case may be. As there can be no absolute measures of abilities, this is the only way we may judge the standing of the individual child. This is obviously most important for the measuring of the degree of retardation or acceleration of a particular ability in a child. Thus if a boy is constantly failing in school work commensurate with his age level, it is necessary to discover whether or not this is due to his being advanced in school beyond his mental age level.

iv. The wide range of reliable standardized tests enables the clinician to get a reasonably accurate and comprehensive picture of the various abilities and characteristics of the child as an individual and compared with his compeers. The test results and observations taken in conjunction with the other data make possible a diagnosis, which rests not on subjective impressions but on material which can at any time be checked by the same or other workers. The use of standardized tests facilitates the comparison of diagnoses and interchange of opinions between workers within a clinic, and through the media of journals and meetings between workers in the entire field throughout the world. This has led not only to a refining of the means of diagnosis, but also to a deeper understanding of the dynamics and nature of whatever is being tested. Tests not only test individuals but theories as well.

Having indicated some of the outstanding advantages of psychological tests in clinical practice, it is necessary to point out certain dangers associated with their general use.

i. Competence in the administration of tests is of course a pre-requisite for anyone using them, but this competence is of little use unless the tester is thoroughly competent to interpret the test results. Unfortunately the idea has grown up that anyone with a book of instructions can give tests, an erroneous, even dangerous notion. Both the administration and interpretation of tests require training, experience, and knowledge of psychological theory. A teacher of a special class ("opportunity grade") told the writer with some pride that he had found a boy who was absolutely normal, he had an I. Q. of exactly 100, yes, 100 to the decimal point! This may seem an extreme case, but actually it is no worse than the liberal distributing by educators and psychologists in some quarters of I. Q. tags as if they had some encyclopaedic connotation.

A test only gives an evaluation of a particular performance, at a certain time and under certain conditions. Though we can expect that a similar result would be obtained on another occasion, this is not always the case. Moreover the test result because of the very nature of the test conditions should be generally regarded as a minimum score rather than an exact measurement. It must also be remembered that the test result can only be understood in terms of the background of the subject and other available data. Thus an I. Q. of 90 will mean something very different for the son of a professional father in a family distinguished for its scholarship, than for a boy

who comes from a family in which none of the members has gone beyond elementary school. Diagnosis should never be made on the results of one test, or even a number of tests, without relating the test findings to all the known and relevant data concerning the case.

ii. No test or tester is infallible, because we are dealing with human beings. Probably the tests that attempt to eliminate entirely the human element are those most liable to err. Consequently testers must always be on their guard against mistakes in administration and interpretation, and need to be modest in their claims for a particular test. In the past all sorts of things have been claimed for tests without adequate foundation, especially in the field of vocational guidance, which has been the department of applied psychology most readily exploited by untrained enthusiasts and dishonest impostors posing as "personality experts" and the like. Even reputable, highly-trained psychologists can become so excited about a test, particularly if it is their own, that they may try to make it do much more than is actually possible.

iii. Before using a test one should be aware of the nature of its standardization. A great many tests are being developed and sold on the market without adequate standardizing, either the groups on which the test was standardized are too small or do not represent a proper sample.[3] Even if the test

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[3] Some of the difficulties of test standardization are discussed by Anne Anastasi in chapter 13 of Fields of Psychology, edited by J. P. Guilford, D. Van Nostrand Co., New York, 1940.

has been satisfactorily standardized, its norms may not be applicable to the situation in question. This is a really serious matter for Australian psychologists as many of the tests they will need to use are not standardized in Australia. It is obvious that norms established with children in schools in Birmingham, England, or Los Angeles, California, may not be reliable for testing children in a rural school in the Mallee, Victoria.[4] This being so, extreme caution must be exercised in the interpretation of results obtained from tests designed for and standardized on children in other countries.

With these general considerations in mind we can discuss more specifically some of the tests that could be used in testing Australian children. It is not suggested that only the tests mentioned here should be used in Australia, and it may be that there are others equally useful, but the ones discussed below all have the recommendation that they have been extensively used abroad with confirmation of their general reliability and validity. The tremendous variety of tests is demonstrated by the fact that the Nineteen Forty Mental Measurements Yearbook reviews over 500 tests, and this is by

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[4] There is a growing literature dealing with group differences, from which may be cited:
Anastasi, Anne, Differential psychology, Macmillan Co., New York, 1937.
Klineberg, Otto, Race Differences, Harper & Brothers, New York, 1935.
---------- Social psychology (Part 3), Henry Holt & Co., New York, 1940.

no means a complete review. However probably the great majority of these tests could not be applied in Australia, not only because of the nature of their standardization, but also because the contents of the tests do not fit local conditions.

2. Psychometrics in Child Guidance.

Basic to the battery of clinical tests are tests of general intelligence.[5] There is still considerable argument among psychologists as to what intelligence is, but there is now general agreement that the intelligence test measures not the limits of an individual's capacity for intelligent behaviour, but rather the actual achievement in a particular situation. Much of the controversy aroused by the Iowa studies on the constancy of the I. Q. would have been unnecessary if all the critics had realized that the I. Q. does not signify an unalterable innate capacity, but simply the level of efficiency or achievement at a given time.[6] The remarkable thing is not that sometimes we get radical alterations in the I. Q. of an individual, but that for the great majority the I. Q. remains relatively constant. The fact that there are changes in I. Q. does not mean that the evaluating of intelligence in terms of I. Q. is not a useful device. Whatever the problem being

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5 For a discussion of the whole question of intelligence see: National Society for the Study of Education. Intelligence: its nature and nuture. Two volumes. Thirty-ninth yearbook. Public School Publishing Co., Bloomington, Illinois, 1940.

6 The results of the Iowa studies dealing with I. Q. changes are discussed by B. L. Wellman: Iowa studies on the effect of schooling, in Part 2 of the work mentioned in note 5; also Wellman, B. L., Skeels, H. M., and Skodak, M. "Review of McNemar's critical examination of the Iowa studies." Psychological Bulletin, 1940, 37:93-111.

studied an accurate estimate of the child's general intelligence is necessary, and when mental retardation or defect is suspected this is of fundamental importance.

Revised Stanford-Binet Scale.

The most frequently used intelligence test and that generally recognized as the most satisfactory within its limits is the Revised Stanford-Binet Scale, a 1937 revision by Terman and Merrill of the earlier Stanford-Binet Scale issued in 1916.[7] Critics agree that the new revision is definitely superior to the old. The standarization and validation are better, the scale has a greater range through the introduction of new test levels at both ends, two separate forms are provided, the L and M scales, and some of the poorer tests such as the giving of age, sex, name, the date, have been omitted. The earlier scale was criticised for being too heavily weighted with verbal material and some still feel that this has not been sufficiently rectified,[8] although Professor Burt believes that the revision has gone too far in this direction and given overemphasis to the practical or manual tests.[9]

The demerits of the scale have received considerable at-

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[7] Terman, Lewis M., and Merrill, Maud A., Measuring intelligence, English edition, George G. Harrap & Co., 1937.

[8] Krugman, M., "Some impressions of the Revised Stanford-Binet Scale," Journal of Educational Psychology, 1939, 30:594-603.

[9] Burt, Cyril, "The latest revision of the Binet intelligence tests," Eugenics Review, 1939, 30:255-260.

tention. The following criticisms may be cited from the extensive literature on the subject:

i. The new revision requires more time for administration, an important matter in clinical work where time is so valuable.

ii. The retention of the year-scale method in the construction of the test makes it unnecessarily cumbersome, repetitious, and wasteful of time and interest.

iii. Rote memory still plays too big a part, particularly at the upper levels.

iv. Much more scatter is found on the new scale, and a single basal or final year is not as conclusive as formerly.

v. A number of tests appear to be misplaced with regard to their difficulty.[10]

vi. In spite of improvements, some of the instructions are liable to be confusing to the child.

In the use of the Scale in British countries there are further difficulties so long as only an American standardization is available. As Burt points out, the American age-assignments and much of the wording are inappropriate to English children.[11]

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[10] This is true of the Scale when used with Australian children according to the report of Dr. D. R. Martin: "Mental tests in clinical practice," Australasian Journal of Psychology and Philosophy, 1940, 18:144-153.

[11] op. cit. (n. 9).
The Scottish Council for Research in Education with the approval of Terman and Merrill has issued a mimeographed revision of the English edition of the test which overcomes the verbal difficulties mentioned by Burt. This revision can be obtained from the office of the Council, 46 Moray Place, Edinburgh.

The vocabulary test has been attacked by both American and British workers for the grading of the words and the mental age levels of the scores. The Scottish Council for Research in Education found that for Scottish children the vocabulary levels were too low, and the writer in a study of patients in an English mental hospital discovered that for this group the American standards were quite inadequate. Thus at the level of "average adult" (mental age 15 years 4 months) the American scale requires 20 words out of 45 defined correctly, the Scottish Council 24 words defined correctly, and the scale established for the English mental hospital 27 words.[12] It can be expected then that for Australian subjects likewise the American vocabulary scale may be unsatisfactory.

A further word of caution concerning the interpretation of the Stanford-Binet is necessary. It is the practice with some workers to analyse the results of the test into the various abilities displayed by the different sub-tests, and so to make generalizations concerning the subject's memory, practical ability, comprehension, reasoning, sensory and perceptual discrimination and other factors.[13] While it may

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12 Report of the Physician Superintendent, Bethlem Royal Hospital, Eden Park, Kent, 1940.

13 An analysis of the factors involved in the earlier Stanford-Binet Scale will be found in the book by F. L. Wells: Mental tests in clinical practice, Yonkers, World Book Co., 1927.

be true that the test samples a number of abilities that are grouped together as "general intelligence", until it has been subjected to thorough factor analysis attempts to evaluate the various factors assumed to be involved in the test items are liable to be of rather doubtful validity. This does not mean that an analysis of the test performance may not give valuable insights diagnostically significant, but it is suggested that in this analysis generalizations from inadequate data, the exact meaning of which is not fully understood, should be avoided.

But when all has been said the Revised Stanford-Binet remains as one of the outstanding contributions to psychometrics, and is a test suitable for Australian use. That so many criticisms of it can be made is a salutary reminder that even the best tests are still very imperfect instruments, an imperfection due in part at least to the nature of that tested.

### Pre-School Tests.

For use with the pre-school child other tests may be preferred to the lower age levels of the Revised Stanford-Binet. Of such tests one of the most widely used is the Merrill-Palmer Scale of Mental Tests for children from 24 to 63 months,[14] first issued in 1926.[15] The great asset of this test is that

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[14] The actual range of the test is from 18 to 78 months, but it is recommended for use only between 24 and 63 months.

[15] Stutsman, Rachel, Mental measurement of preschool children, Yonkers, World Book Co., 1931

it is based on keen insight into the psychology of the child and has been designed to obtain and keep the interest of the young child during the test period. The test is carefully standardized, makes provision for scoring omitted or refused items, and the language element is at a minimum, many of the items permitting direction by pantomime as may be necessary in testing deaf children. Low correlation of the test with the Stanford-Binet shows that it is sampling performances other than those tested by the latter, and therefore should be regarded as supplementary to and not a substitute for it.

It has however certain serious weaknesses. The inclusion of items scored on the basis of speed of performance is not justified at an age when the development of time concepts is so rudimentary. The range of abilities tested is too limited for an adequate understanding of the various developmental factors. While the lack of stress on language has its advantages, this is also a weakness as language development is generally a very important diagnostic criterion. As in this test scores cannot be given in terms of I. Q., standard deviations and percentiles being used, the interpretation of the results requires an understanding of statistics not always possessed by nursery school workers and others desiring to use the test. Unfortunately the cost of the test material ($46.60 per set in U. S. A.) is much too high and this alone will rule the test out for many workers.

A more recent test similar to the Merrill-Palmer is the

Minesota Preschool Scale for ages from 1 year 6 months to 6 years, published in 1932.[16] The test consists of 26 separate items which may be scored in two groups, verbal and non-verbal, as well as giving a total score convertible into percentile rankings, standard deviation placements and I. Q. equivalents. The provision of two test forms, A and B, is an advantage the test has over the Merrill-Palmer, and reduces the practice effect in the event of re-testing. The cost of the test, $9.50 for each form, will commend it to clinics unable to afford more expensive materials. As many of the items of the test are similar to those in the Binet tests, some of them being directly adapted from the Kuhlmann revision of the Binet scale, it would seem that it tests much the same abilities as the Binet Scales.

The chief criticism brought against this test is that it is not as interesting to children as the Merrill-Palmer, that before testing is completed children are apt to become bored by the similarity and repetition of some of the items. It has also been criticised for failing to provide in the scoring for items omitted or refused, and that this makes for inaccuracy in scoring the tests of very young children.[17] Nevertheless it is a test that appears to be growing in popularity

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16 The test was devised by Florence L. Goodenough, Josephine C. Foster, and M. J. Van Wagenen. A manual of instructions is provided with the test material sold by the Educational Test Bureau, Minneapolis, Minnesota.

17 Ball, Rachel Stutsman, "Review of the Minnesota Preschool Scale," 1940 Mental Measurements Yearbook, edited by O. K. Buros, 1941.

and one that can be safely recommended for clinical use.

Although both the Merrill-Palmer and Minnesota tests give a reasonable estimate of the child's abilities at the time of testing, prediction from these tests as to the future status of the child is extremely hazardous.[18] This is no fault of the tests but seems to be due to the fact that the child is a growing, changing, developing organism.

It is convenient at this point to refer to the use of developmental schedules at the lower age levels. A Child Development Chart for Australian children has been drawn up by Dr. Lois Hayden Meek and Miss Christine M. Heinig, who borrowed their material from both Australian and overseas sources.[19] Probably the most systematic effort in this field is that of Dr. Arnold Gesell and his collaborators at the Yale Clinic of Child Development. Taking the concept of growth as the key for the interpretation of individual differences, it is claimed that there are laws of sequence and of maturation which account for the general similarities and basic trends of child development. Accordingly developmental norms are established for motor development, adaptive behaviour, language development, and personal-social behaviour. The first developmental schedule was published by Gesell in 1925, and was established with a normative group of 50 children, the norms being from

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[18] This is discussed by Ruth Updegraff: "The determination of a reliable intelligence quotient for the young child," Journal of Genetic Psychology, 1932, 41:152-166.

[19] Heinig, Christine M., The child in the nursery school, David Syme & Co., Melbourne, 1937.

birth up to six years of age.[20] In 1928 a second schedule was published, based on an intensive study of 24 children, with norms from 4 weeks through 56 weeks.[21] Experience gained in these earlier studies led to a further study with a normative group of 107 selected children, resulting in a more refined developmental schedule with norms from 15 months through 6 years.[22]

Although the Yale developmental norms are the result of years of careful study of hundreds of preschool children, typical and atypical, the actual norms are based on very small and unrepresentative samples, so that while they may indicate the developmental sequence and rate of maturation of the children studied, they do not necessarily apply to children from very different groups. As the application of the schedules is by means of matching the behaviour of the child with the norms, as Gesell admits, this represents difficulties when development is asymmetrical. For the worker skilled in conducting the examination of young children these schedules will be a valuable guide, but for others they may be misleading and confusing.

Group Tests of General Intelligence.

Sometimes a group intelligence test may be needed, which,

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20 Gesell, Arnold, The mental growth of the preschool child, Macmillan Co., New York, 1925.

21 Gesell, Arnold, Thompson, Helen, and Amatruda, C. S., The psychology of early growth, Macmillan Co., New York, 1928.

22 Gesell, Arnold, et al., The first five years of life, Harper & Brothers, New York, 1940.

because of the ease and speed of administration may serve as a substitute for, or supplement to, the regular individual testing instrument. Fortunately two such tests have been standardized by the Australian Council for Educational Research.[23] The Otis Self-administering Test is an adaptation of the American Otis Test and is established for two age groups, the Intermediate Examination for ages 9-15, and the Higher Examination for ages 13-17. The disadvantages of the Otis are inherent in the nature of such tests: it is entirely verbal, speed is a major factor, and the subject may not be as well motivated as in other types of test.

At the same time the Otis tests were being standardized in Australia, a second test devised by the Australian Council for Educational Research was developed, the A. C. E. R. Non-Verbal Test. It is for the same age group as the Intermediate Otis, and consists of four sections each taking six minutes for administration, the sections being: classifications, spatial relationships, analogies, time sequences.[24] The test suffers from two of the shortcomings of the Otis, the major role played by the time element, and the possible inadequacy of motivation. However, both the Otis and A. C. E. R. Non-Verbal tests are useful additions to the Australian clinical test battery if used with an understanding of their limits.

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[23] McIntyre, G. A., The standardization of intelligence tests in Australia, Melbourne University Press, 1938.

[24] Ibid.

Vineland Social Maturity Scale.

Psychologists have long felt the need for a clinical test which would give a measure of social competence or social maturity. In cases of mental retardation in addition to the estimate of general intelligence as stated by an I. Q., an evaluation of the individual's social adjustment is most important.[25] That so few tests have been developed in this field is probably due to the variety of factors involved, intelligence, emotional organization, personality traits, physical development, opportunities for training in social behaviour and independence. One test that warrants special mention is the Vineland Social Maturity Scale devised by Dr. E. A. Doll of the Vineland Training School, New Jersey, a pioneer effort in this aspect of psychometrics.[26]

The Scale covers all ages from infancy to adulthood (25 years), and consists of 117 items graded in age levels, designed to indicate the subject's attainments in self-help, self-direction, locomotion, occupation, communication and social relations. The Scale is not administered to the subject,

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[25] Mental defect is often defined in terms of social competence. Thus the Mental Deficiency Act 1939 (Victoria, Australia) defines imbeciles as "persons in whose case there exists mental defectiveness which is so pronounced that they are incapable of managing themselves or their affairs or, in the case of children, of being taught to do so."

[26] Doll, E. A., The Vineland social maturity scale. Manual of directions, The Training School, Vineland, New Jersey, 1935.

but is scored on the basis of information obtained from parents, and others familiar with the behaviour of the subject. A social quotient (S. Q.) is obtained by dividing the test social age by the life age. The advantages of this test are that it can be used repeatedly with the same subject and so indicate improvement or deterioration in social competence, it is easily administered, and it reveals the deviations in behaviour which are significant for the diagnosis of mental deficiency, social maladjustment and other conditions in which the degree of independence achieved by the individual is important.

The title of the test is a little misleading, for by social maturity Doll means the development of independence, which though a feature of maturity does not cover everything usually considered as belonging to this term. The method of applying the Scale, in spite of the directions for securing accurate responses from the informant, introduces subjectivity which in this case is a likely source of error. The test items at the lower age levels are probably adequate, but at the middle and upper levels do not permit of accurate evaluation. Thus at level IX-X there are only three items: cares for self at table; makes minor purchases; goes about home town freely. This is a serious weakness, for it is in the middle age range that an accurate measure of social maturity and competence is very often needed. Nevertheless, with all its shortcomings the Scale is a useful instrument, and points the way to further work in this interesting area of testing.

Performance Tests.

Another group of tests which should be represented in the test battery of every clinic are those known as performance tests. As tests of intelligence such as the Stanford-Binet depend so much on the understanding and use of language they are of little use with deaf children, foreign children and those from homes that have not given them adequate opportunity for developing verbal ability. Consequently performance tests have been devised that do not depend on verbal ability, and which in most cases can be given without verbal instructions. These tests are not only valuable as substitutes for other kinds of intelligence tests, but also as supplementary to them in that they give an opportunity for the examiner to observe various aspects of behaviour, perseverence, patience, foresight, motor co-ordination, initiative. There is a great variety of such tests: form boards,[27] picture completion,[28] construction,[29] maze tracing,[30] drawing,[31] and performance scales combining a

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[27] For example, the Seguin form board. Wallin, J. E. W., "Norms for the Seguin form board based on the average of three trials," Journal of Delinquency, 1921, 6:381-386.

[28] For example, Healy picture completion test. Healy, William, "A pictorial completion test," Psychological Review, 1914, 21:189-203.

[29] For example, Pintner-Paterson Manikin test. Pintner, R. and Paterson, Donald, A scale of performance tests, Appleton-Century, New York, 1917.

[30] For example, Porteus maze test. Porteus, S. D., The maze and mental differences, Vineland, New Jersey, Smith Publ. Co., 1933.

[31] For example, Goodenough drawing test. Goodenough, Florence, Measurement of intelligence by drawing, World Book Co., Yonkers, 1926.

number of different tasks.

Mention can only be made of several of the better known performance scales. The Alexander Performance Scale for ages 9 years and over consists of the passalong test, block Design test, and cube construction test.[32] The Arthur Point Scale of Performance Tests is for ages from 6 years and upwards, has two forms including such tests as cube imitation, Seguin form board, two figure form board, casuist form board, manikin and feature profile, mare and foal test, Healy picture completion, Porteus maze, Kohs block design.[33] The Cornell-Coxe Performance Ability Scale has one form for ages from 4½ to 16 years and consists of seven tests, manikin and feature profile, block design, picture arrangement, digit-symbol, memory for designs, cube construction, and the Healy picture completion test 2 (this is an additional test that may be used as a substitute for the picture arrangement test).[34] This last mentioned performance scale has the advantages of being cheaper than some of the others, and of having very clear, unequivocal directions. Of the older scales the Pintner-Paterson Scale is probably the

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[32] Alexander, W. P., "A new performance test of intelligence," British Journal of Psychology, 1932, 23:52-63.

[33] Arthur, Grace, A point scale of performance tests, Volume 1, clinical manual, 1930.
---------- A point scale of performance tests, Volume 2, The process of standardization, 1933, Commonwealth Fund, New York.

[34] Cornell, E. L., and Cox, W. W., A performance ability scale: examination manual, Yonkers, N. Y., World Book Co., 1934.

most widely used; it has fifteen tests, and may be used either in a long or short form.[35]

All the above performance scales have demonstrated their utility as clinical instruments, which of these should be employed in a child guidance clinic will depend very much on the preferences of the psychologist.

Achievement Tests.

In cases of unsatisfactory adjustment or progress in school it is often necessary to use one or more tests of scholastic achievement. Both in Britain and America a great variety of achievement tests have been developed, but owing to the differences in education between these countries and Australia few of these tests can be applied safely to Australian children. This is not a serious matter as similar tests have been set up by the Australian Council for Educational Research.[36] The A. C. E. R. Arithmetic Test is suitable for children from the third to the eighth year of school life, and consists of six sections: addition, subtraction, multiplication, division, mechanical arithmetic, problem arithmetic. The Reading Test, also for children from the third to the eighth year of school life, is of five parts: word knowledge, speed of reading, general significance, details, inference. The Individual Reading

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[35] op. cit., (n. 29).

[36] Australian Council for Educational Research, Tests published and standardized for use in Australia, June, 1937.

Test is for diagnostic purposes in the lower primary grades, and has three sections: word reading, reading comprehension, speed of reading.

As reading ability is basic to most of the subjects in the school curriculum, a child with special reading disability may very easily be judged to be generally backward or even mentally defective, consequently careful attention should be given to this matter. When a child having difficulty in reading is discovered the Monroe Diagnostic Reading Examination can be given to learn the nature of the difficulty, word reversals, confusion of letters, substitutions, whatever the trouble may be.[37]

The A. C. E. R. Spelling Test is suitable for grades above Grade 2, norms being for age-grade levels and are given for each State. A Chemistry Test has also been designed, but this is not of interest for child guidance.

Aptitude and Personality Tests.

Mention should also be made of tests of specific abilities and interests which may be useful in cases where vocational guidance is indicated. Examples of tests of aptitudes in particular fields are the Seashore Measures of Musical Talent,

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[37] Monroe, Marion, Children who cannot read, University of Chicago Press, 1932.
See also: Gates, Arthur I., The improvement of reading. A program of diagnostic and remedial methods, Macmillan, New York, Revised edition, 1935.

Detroit Mechanical Aptitude Test, Minnesota Vocational Test for Clerical Workers; other tests may be found in the literature cited at the end of this chapter. Tests of attitudes and interests have been prepared to cover a wide field, vocational, recreational, personal and social subjects. Although most of these tests tend to be rather superficial and are open to considerable conscious and unconscious distortion by the testee, they sometimes give a useful index of the interests and preoccupations of the subject.

Hundreds of tests, inventories, rating scales and other devices have been created for the purpose of evaluating various aspects of personality, but few of them justify the claims that are made for them. Among the better known of these tests are Pintner's inventory for grades 4-9, Aspects of Personality, Woodworth's Personal Data Sheet, the Personality Rating Chart for Preschool Children (Merrill-Palmer School), the Bernreuter Personality Inventory, the Haggerty-Olson-Wickman Behavior Rating Scales. These tests, formerly so popular, are now giving place to techniques which appear to be much more satisfactory, namely the projective tests which will be discussed in the next section.

### 3. Projective Techniques.

As Lawrence K. Frank has pointed out, individuals may be regarded as existing in (a) the common public world of nature, (b) the social world of culturally determined patterns, (c)

private worlds developed under the impact of experience.[38] However similar environmental and cultural conditions may be for individuals in any given situation no two will react quite the same. This can easily be demonstrated by suggesting to a group a simple, commonplace stimulus word such as table. One will respond by thinking of the word, table; another will think of something with four legs and a flat top; another will think of a particular table, perhaps a kitchen table; someone else thinks of a statistical table; others will think of operating tables, marble tables, paintings of tables, and so on. Frank, in discussing the meaning of this for the study of personality, sums up the position thus: ". . . we may emphasize then that personality is approachable as a process or operation of an individual who organizes experiences and reacts affectively to situations. This process is dynamic in the sense that the individual personality imposes upon the common public world of events (what we call nature), his meanings and significances, his organization and patterns, and he invests the situations thus structured with an affective meaning to which he responds idiomatically."[39]

It is this idiomatic nature of the individual's meanings, significances, organization and affectivity, that we are interested in investigating in the clinical study of personality.

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[38] Frank, Lawrence K., "Projective methods for the study of personality," Journal of Psychology, 1939, 8:389-413.

[39] Ibid.

And it is this which can be missed in many of the regular inventory type of personality tests as the subject tends to respond according to the recognized social demands, only the more superficial levels of the personality being revealed. But if the test material given to the subject is relatively unstructured and free from cultural patterning, the testee can respond idiomatically, imposing himself on it, projecting into it his deeper personal needs, strivings and desires, freely interpreting it and reacting affectively to it. This is the general theory behind the construction of what are now known as the projective techniques for the study of personality. Because these techniques have already demonstrated their clinical usefulness and their superiority over the paper-and-pencil personality tests, a brief discussion of some of them will be given.

### Rorschach Ink-Blot Test.

A projective test that has aroused considerable interest, particularly in the last two or three years, is the Rorschach Ink-blot Test. Although ink-blots had been used by a number of workers investigating problems of thinking, memory, imagination and other mental processes, the first and most important attempt to use ink-blots for a thorough study of personality was that of Hermann Rorschach, who reported on his work and published his method in 1921.[40] Since then Rorschach's method has been

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[40] Rorschach, Hermann, Psychodiagnostik. Methodik und Ergebnisse eines Wahrnehmungsdiagnostichen Experiments, Bern, Bircher, 1921.
--------- ------- Psychodiagnostik, Bern, Huber, 1932.

used extensively in Europe by such workers as Oberholzer (now in New York), Behn-Eschenburg, Schneider, Loosli-Usteri, Verschuer, Löpfe; and in America by Beck, Hertz, Piotrowski, Klopfer, and many other leading psychologists, until the literature on the method runs into hundreds of journal articles and one entire journal is devoted to it alone.[41] Probably no test is at present being used in so many different countries and is arousing such great interest on the part of psychiatrists and psychologists, as is the Rorschach method.

The test consists of ten cards on which are printed photographic reproductions of various ink-blots, five black or grey, two black and red, and three multicoloured. The cards are presented in a definite sequence to the subject who is asked "What might it be?" Reaction times are noted, and the responses recorded verbatim are later scored and interpreted according to certain criteria.[42] From the record the experienced Rorschach worker can make a fairly accurate estimate of the intelligence level, the quality of the intellectual processes, the actual efficiency level, the basic personality pattern, the nature of the control and personality organization, the emotional develop-

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41 Rorschach Research Exchange, published quarterly by the Rorschach Institute Inc., New York.

42 Klopfer, Bruno, "The technique of the Rorschach performance," Rorschach Research Exchange, 1937, 3:1-14.
---------- et al., "Theory and technique of Rorschach interpretation," Rorschach Res. Ex., 1940, 3:152.
----------, and Davidson, Helen, Record blank for the Rorschach method of personality diagnosis. Rorschach Institute, New York, 1939.

ment, the presence of such factors as anxieties, phobias, obsessions, and other symptoms of abnormal personality development, and the nature of the person's interests and attitudes. These are seen not as isolated and independent factors, but as aspects of the personality as a dynamic, functioning configuration or whole.

The value of the Rorschach method is that it gives this complete picture of the personality in operation, that it goes much deeper than more formal types of test, and consequently is of considerable utility as a psycho-diagnostic instrument. Because the test material is non-verbal and free from features specific to any particular age level, social or racial group, it can be used for all ages at which verbalization is possible, for members of any cultural group, and for conditions ranging from normality to the grossest of abnormal states.

For the application of the test a thorough training in psychology and broad experience in psychopathology are necessary, as well as adequate training in the technique itself, the latter now being provided by the Rorschach Institute, New York.[43] The technique can only be mastered as the result of intensive study and by giving a great many tests to a wide range of subjects, a deterrent fortunately to those who are

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[43] Courses dealing with the Rorschach method are conducted in a number of American universities and psychiatric centres. It is not suggested, however, that only those who have had such formal training are competent to administer the method.

seeking some easy formula which will enable them to find simple solutions to the problems of personality. A disadvantage of the method has been the lack of standardization of the scoring procedures and diagnostic criteria, but advances have been made recently which reduce, if not eliminate, this shortcoming.[44] However, because of the very nature of the method, scoring and interpretation will never be reduced to precise statistical tables which some regard as the mark of objectivity in science; there will always be much that will depend on the experience and insight of the worker.

Thematic Apperception Test.

The Thematic Apperception Test devised in the Harvard Psychological Clinic is another promising form of projective test.[45] It is a method of investigating personality by presenting a series of pictures and encouraging the subject to construct fantasies around them, thus penetrating below the peripheral personality and revealing latent strivings, needs, feelings and attitudes that the subject would be unwilling to disclose in a more direct way. The test material consists of thirty mounted pictures, the first ten for both sexes, then ten for female subjects only, and ten for males only. Four

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[44] Reports of this work are to be found in the Rorschach Research Exchange and other journals.

[45] Murray, H. A., et. al., Explorations in personality, Oxford University Press, New York, 1938.
White, R. W., and Sanford, R. N., Directions, Thematic Apperception Test, Harvard Psychological Clinic, 1941.

of the cards are omitted when the test is given to children, the remaining twenty six being quite satisfactory. The subject is told: "This is a test of creative imagination. I am going to show you some pictures. Around each picture I want you to compose a story. Outline the incidents which have led up to the situation shown in the picture, describe what is occurring at the moment--the feelings and thoughts of the characters--and tell what the outcome will be. Speak your thoughts aloud as they come to your mind. I want you to use your imagination to the limit."[46]

The resulting material can be analysed in a variety of ways according to the particular interests of the psychologist. Possible ways of analysing the results suggested in the manual of directions are (a) how the subject uses his mind, distinguishing the following variables: imaginal productivity; organization; verbal conjunctivity; intraception; and (b) the dynamic content, the needs and presses as revealed in: determination of the principal character; determination of the main thema in each story; recurrent or dominant themas; adequacy of principal characters; conditions under which good and bad endings occur; conditions under which specific needs are allowed gratification; attitudes toward parent and sibling figures;

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[46] White and Sanford, Directions, Thematic Apperception Test, pp. 4-5.

figures introduced by the story-teller; objects introduced by the story-teller; signs of inhibition.

This technique is one that it is interesting to tester and testee, and certainly produces much material that throws light on the way the subject is reacting to the needs and pressures of life. Analysis of the material requires a great deal of experience with the test, and even then presents considerable difficulty in some cases. The subjective nature of the analysis and interpretation will not commend the test to those who believe that tests should be based on clearly demonstrable criteria and standardized procedures, and it must be admitted that this test does permit of too much subjectivism. Administration of the test usually requires two sessions of an hour each, and to this must be added the time spent in analysing and interpreting the results, rather a heavy demand on the time of the busy clinician. Even if the Thematic Apperception Test cannot be employed in routine testing, for special cases and research purposes it will be most useful, and as a new approach to personality study it has opened up avenues of investigation that should prove very fruitful.

Free and Controlled Association Methods.

Mention must be made of the word association methods that were widely used before the advent of the newer projective techniques. In the free association method as employed in psycho-analysis the subject is asked to respond freely with

all his verbal associations. In the controlled association methods as developed by Jung[47] and later by Kent and Rosanoff,[48] the subject is read a list of stimulus words to each of which one response word is given. Reaction times and responses are noted, and then the list is re-read and the subject asked to recall the responses given on the first occasion. The reaction times, the nature of the verbal associations on both occasions, and the test behaviour of the subject contribute to the interpretation of the personality and problems of the subject. As supplementary to other test procedures the association methods are undoubtedly useful instruments for probing the personality.

Other projective techniques for the study of personality are the cloud pictures of Wilhelm Stern,[49] finger painting,[50] plastics,[51] puppetry,[52] handwriting,[53] and play activities.[54]

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47 Jung, C. G., Studies in word associations, Moffat, Yard & Co., New York, 1919.

48 Rosanoff, A. J., Manual of psychiatry, John Wiley & Sons, New York, 7th edition, 1938.

49 Stern, W., and Macdonald, J., "Cloud pictures: a new method of testing imagination," Character and Personality, 1937, 8:132-146.

50 Shaw, R. F., Finger painting, Little, Brown & Co., Boston, 1934.

51 Bender, Lauretta, and Woltmann, Adolf, "Use of plastic material as a psychiatric approach to emotional problems in children," American Journal of Orthopsychiatry, 1937, 7: No. 3.

52 Bender, Lauretta, and Woltmann, Adolf, "The use of puppet shows as a psychotherapeutic method for behaviour problems in children," American Journal of Orthopsychiatry, 1936, 6: No. 2.

53 Stein-Lewinson, Thea, "An introduction to the graphology of Ludwig Klages," Character and Personality, 1938, 6:163-177.

54 Gitelson, Maxwell, et. al., "Symposium on play therapy," American Journal of Orthopsychiatry, 1938, 8:499-526.

These are all based on much the same theory as the two methods discussed above, that in situations where the individual is relatively free from commands and other restricting influences his behaviour will express its truly individual character, and from it can be deduced much concerning the organization, dynamics and operations of the personality.

Play Techniques.

The play interview, which will be discussed further in the next chapter on therapy, is proving a valuable supplement to the more formal testing and interview procedures. The general tendency in child psychology is to provide as far as possible real life situations in which to test children, and play is something that enables the child to display behaviour which could be expressed satisfactorily in no other way because it is a natural medium for expression by children. Although play interview methods vary, when the purpose is diagnostic the general procedure usually is to provide the child with a variety of toys, such as guns, motor cars, blocks, clay, drawing materials, paints, toy furniture and small dolls of different kinds to represent men and women, boys and girls, a family in miniature, the choice of material depending to some extent on the age of the child. During the play interview which is for about an hour, the psychologist plays a passive role, simply observing the child's behaviour, perhaps asking an occasional question or if it is necessary carrying on some conversation to ease the child's feeling of strangeness. Sometimes the

psychologist may join in the play if this is suggested by the child, but care must be taken to see that the play is directed entirely by the child.

The play interview has much to recommend it and nothing against it. The equipment need not be elaborate, indeed it is better so, and can be bought for a few shillings. An hour is not too much to spend on this important approach to the understanding of the child. Any psychologist without special training in the technique can begin to use it with advantage the first time he conducts an interview. Particularly with young children it is an excellent way of establishing rapport essential for subsequent therapy. In the play session the child will reveal behaviours and attitudes towards his parents and other members of the family that may not be otherwise disclosed. The child's play will reveal also something of his manual dexterity, imagination, initiative and other abilities. One has only to try the play interview once or twice to be convinced of its worth as a routine procedure.

Although it is not strictly a projective technique, the recreation study as used by the Institute for Juvenile Research, Chicago, is somewhat similar to the play interview method.[55] The Institute has devised outline forms (for ages 9-15, 16 and

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[55] Staff of the Institute for Juvenile Research, Child Guidance procedures, D. Appleton-Century Co., New York, 1937, Chapter 8.

over, and adult) according to which an interview is conducted with the child in order to obtain information concerning his play interests and preferences, personal possessions and recreation facilities, attitudes toward play mates and parents, organized recreational activities such as Scouts and Guides, clubs and play groups, and other matters associated with how the child uses his free time. Much of this material is often obtained in the psychiatric interview and social history, but the Chicago Institute believes that a more systematic study of this important aspect of the child's life is desirable. Not only is this information on recreational activity valuable in itself, the recreation study will furnish a great deal about the child's attitudes towards the school, the home and family, and similar significant factors in the life situation. The recreation study contributes insights helpful in diagnosis and suggestive of therapeutic measures which might be employed.

The projective methods that have been discussed are still in need of further investigation and experiment, and so should be used with caution, but already they have convincingly demonstrated their advantage over many of the older techniques. Of course projective tests alone are not sufficient for a reliable diagnosis; they are to be used along with the social history, the psychiatric and physical examinations, and the appropriate standard psychometric investigations, thus giving a complete picture of the whole individual as operating in, and part of, a particular life-situation or social field.

In view of the great variety of psychological techniques, the constant revision of established methods and the devising of new ones, child guidance workers need to guard against becoming rigidly devoted to particular testing instruments. As the value of tests varies according to the needs of different clinics, the alert clinician will continually experiment with old and new tests in order that further understanding of their utility may be gained, and so that methods most appropriate to the clinic may be discovered.

## Bibliographical Note.

For a further discussion of the diagnostic study the following books are suggested:

Louttit, C. M., Clinical psychology, Harper & Brothers, New York, 1936.
Staff of the Institute for Juvenile Research (Paul L. Schroeder, Director), Child guidance procedures, D. Appleton-Century Co., New York, 1937.

Comprehensive information of psychological tests is given in the following:

Cattell, R. B., A guide to mental testing, University of London Press, 1936.
Hildreth, G. H., A bibliography of mental tests and rating scales, Second edition, Psychological Corporation, New York, 1939.
Buros, O. K., editor, Nineteen thirty eight mental measurements yearbook, Rutgers University Press, New Brunswick, 1938.
----- ---------- Nineteen forty mental measurements yearbook, Mental Measurements Yearbook, New Jersey, 1941.

# CHAPTER VI

## THERAPY IN CHILD GUIDANCE

### 1. General Trends in Therapy.

The tremendous interest in therapy as manifested by the amount of space devoted to it in medical, psychiatric and psychological journals, and as expressed in vigorous controversies in the various professions concerned, is a comparatively modern development. This interest is due in part to the increasing recognition by society of the burden imposed on it by the presence in the community of diseases and personality disorders of one kind and another. Thus we have campaigns against cancer, venereal diseases, drug addiction, alcoholism and crime, and community programmes in mental hygiene and public health. It is difficult to obtain accurate estimates of the extent and cost to the community of some of these conditions, but a study of any one of them will show that if adequate therapy could be undertaken it would represent considerable saving of human and economic resources. Professor J. F. Brown has estimated that five out of every one hundred individuals will be at some time in their lives hospitalized for a mental disorder.[1] Horatio M. Pollock has

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[1] Brown, J. F., The psychodynamics of abnormal behavior. McGraw-Hill Book Co., 1940, p. 278.

calculated that the economic loss due to hospital cases of mental disease in the United States during the year 1936-1937 was $783,586,000, and the loss for the same period on account of people suffering with mental disease outside of institutions, $331,591,000.[2] Society has very good reason to be seriously interested in preventive medicine and mental hygiene, and inasmuch as prophylactics do not apply to those already suffering from various disorders, therapy is necessarily a major concern.

A universal and traditional way that societies have had for dealing with those who seriously deviated from the accepted standards of health and behavior was to exclude them from the group. In primitive societies this often meant complete ostracism or death, in modern times it has meant institutionalizing the deviants in the interests of the well-being of the group. While institutionalization was the accepted remedy for the different mental and physical disorders, it was natural that medical science should be occupied chiefly with problems of diagnosis and classification. But the futility of merely diagnosing and segregating those requiring such treatment became apparent

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[2] Pollock, Horatio M. Economic loss due to mental disease in New York State and the United States, 1937. American Association for the Advancement of Science, Publication No. 9, 156-164.

with the increasing burden of this problem, and with the advances being made in the biological and social sciences, attention began to be given to the question of therapeutic measures that might be used with at least some of the groups previously given little more than custodial care.

As was pointed out in Chapter II, the systematic treatment of children with personality and behaviour problems is something that has developed during the last two or three decades. It is interesting to note that Healy's "Individual Delinquent" published in 1915, which exerted a profound influence upon thinking concerning delinquency and cognate problems, gave but the scantiest discussion of treatment techniques, actually only 13 pages in 800 being concerned specifically with the subject. It has been seen that with the development of psychiatry, clinical psychology, and psychiatric social work, a development that made possible the establishing of child guidance as we now know it, a new approach to the question of treatment procedures emerged. To this new approach to treatment child guidance has made a notable contribution. The co-operation of the psychiatrist, psychologist, and psychiatric social worker in the clinical team has thrown considerable light on the dynamic nature of the individual's relationship to the environment and other individuals in that environment. The child guidance clinic soon discovered that attempts to explain behaviour simply in terms of behaviour patterns abstracted from the field in which they operate, or in terms of

environmental factors such as poverty and slums irrespective of other equally significant factors in the total situation, were bound to be unsatisfactory foundations for effective therapy.[3] The attack must be on the total personality in the total situation, an organismic, field theoretical approach.

Closely related to this view of the dynamic relationship between the individual and his total environment or social field, and equally important for therapy, is the modern solution to the body-mind problem. Until the beginning of the present century medicine and with it psychiatry had adopted a somatogenic approach to disease and mental abnormalities. It was felt that eventually all mental disorders could be reduced to brain pathologies, a view that dies hard even today. Over against the somatogenic point of view was that held by some philosophers, psychologists, and psychiatrists who were influenced by the theories being built around hypnosis, suggestion, and later psycho-analysis, a view that many of the mental abnormalities were due to strictly psychogenic factors, and hence their understanding and treatment could only come through the discovery of psychological laws and processes.[4]

The position now gaining general acceptance is that the answer is to be found neither in a somatogenic nor a psychogenic theory, but in a psychosomatic one, an organismic approach.

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[3] The child guidance approach is well illustrated in the case studies presented by Mary B. Sayles in Child Guidance Cases, Commonwealth Fund, New York, 1932.

[4] The development of modern psychiatry is ably described by William A. White: Twentieth century psychiatry, W. W. Norton & Co., New York, 1936.

The individual, whether viewed as body or mind, functions as an integrated, total unit. This means that every condition however organic and physical the causative factors and symptoms may appear involves psychological factors as well. Similarly every so-called psychological problem involves organic factors that must be taken into account. For convenience we may deal with the body and mind as separate entities and speak of psychological and organic causes and conditions, but it must be remembered that these are only distinctions made for methodological purposes. This psychosomatic, organismic view is not only of theoretical significance, it is also extremely important in diagnosis and therapy.

Any therapeutic programme initiated in a child guidance clinic should then be one that is based on an understanding of the child as total personality functioning in a particular situation that is an active, dynamic ingredient in the broader field of which the child is part. If these fundamental principles had been recognized earlier much needless, though not always unfruitful, controversies would have been avoided. Debates as to the place of psychiatrists, psychologists and social workers in treatment programmes, rivalries between different schools of thought concerning therapeutic techniques, individual - versus - environment arguments, all stem from misconceptions overcome by the organismic, field theoretical approach to the problems of child guidance.

The extensive literature on therapy in child guidance

abounds in technical terms that often obscure rather than illuminate the problems involved, various workers having coined their own terms to describe their techniques; and one is confronted with a rather bewildering battery of therapeutic devices all having enthusiastic supporters. So we hear of direct and indirect, active and passive, individual and group, superficial and deep, therapeutic procedures all having their specific titles. Professor Poffenberger has listed 15 therapies, and this is not a complete list, some of these being: tutoring therapy, play therapy, habit therapy, affect therapy, attitude therapy, suggestion therapy, occupational therapy, psychoanalysis, physiotherapy and medical therapy.[5] In the following pages various therapeutic procedures will be reviewed under two arbitrary headings, those which treat the child indirectly by effecting environmental changes, and those dealing with the child directly in a therapeutic relationship. Naturally in the limits of this present study a really comprehensive and detailed treatment of all the possible techniques cannot be undertaken.

## 2. Indirect Therapies.

### Institutional Placement.

As the institution had been the answer to the question

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[5] Poffenberger, A. T., "Specific psychological therapies," American Journal of Orthopsychiatry, 1939, 9:755-760.

of providing for the insane, mental defective, criminal, and other groups requiring either for their own sakes or for the sake of the community some form of care, it was quite natural that this should appear as an easy, reasonable way to cope with the problems of difficult and delinquent children. Early workers dealing with problem children were strongly impressed by the presence in the majority of cases of unsatisfactory environmental conditions, slums, evil home influences, bad companions, opportunities for acquiring anti-social habits. The obvious solution seemed to be to remove the child from the undesirable environment, place him in an institution, and by a programme of discipline, instruction, and if necessary punishment, strengthen his character so that when he was discharged he would be able to resist temptation, and so grow into a good citizen.

Unfortunately this simple solution has proved to be no real solution at all. Institutional life instead of reforming and building strong, healthy characters, has tended to give children and adolescents a distorted, bitter attitude towards society, and often strengthened their desires to get even by means of crime with the world that they feel has used them badly. It is generally recognized that reformatories do not reform delinquents, and that all too often they are but training schools for criminal careers. One of the few systematic studies of the post-reformatory records of a large group of reformatory inmates is that made by Sheldon and Eleanor Glueck of 510 inmates of the Massachusetts Reformatory, Concord. They

discovered that five years after parole of 422 who could be traced, 80 per cent were again offenders, 44 per cent committing serious crimes resulting in penal sentences.[6] However, the record of the English Borstal System, the finest reformatory system in the world, has demonstrated that much better results than those reported in the Gluecks' study can be obtained.[7] Of course there are so many types of institution for children that general observations are somewhat hazardous, but certain disadvantages associated with the institutional treatment of problem and delinquent children call for comment.

Most institutions because of the nature of their organization, the design of the buildings, the lack of adequate facilities, and the poorly paid, untrained staffs, of necessity tend to follow rigid, regimented procedures. Thus children who more than any others need individual treatment are subject to impersonal, mass methods that give superficially satisfactory results but in reality often aggravate problems. Many institutions are characterized by moralistic, up-lift attitudes and stern disciplinery, punitive methods against which most children naturally revolt. The principal shortcoming of institutional life is that it is usually quite unrelated to the world outside

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6 Glueck, Sheldon, and Glueck, Eleanor, Five hundred criminal careers, New York, Knopf Inc., 1930.
------ ------- --- ------ --------, Later criminal careers, New York, Commonwealth Fund, 1937.

7 Healy, William, and Alper, Benedict S., Criminal youth and the Borstal System, New York, Commonwealth Fund, 1941.

in which the youngsters eventually have to take their place. The system of rewards and punishments, the taboos and restrictions, the attitudes and practices of the institution provide an artificial environment so unlike the real world that the individual instead of being prepared for the problems of everyday life, is often thrown out to face them with a heavy handicap.

The disadvantages of institutional life are being overcome in some institutions by the introduction of more individualized treatment, the use of the cottage system with specially qualified housemothers and housemasters, the granting of more freedom and self-government to the inmates, and the integrating as far as possible the activities of the institution with that of the outside community. These advances must be encouraged, as some institutions will probably always be needed, for despite the weaknesses of institutional care and treatment there are cases when this is the only or the best plan for children and adolescents.[8]

Institutional placement is indicated for most mental defectives, children suffering from such disabilities as blindness, epilepsy, and other physical conditions requiring treatment that cannot be satisfactorily conducted in the home. Spoilt, egotistical children who have successfully dominated

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[8] A fascinating study of the individual and his relation to social groups that is relevant to this problem of institutional placement is presented by J. L. Moreno: Who shall survive? A new approach to the problems of human interrelations. Nervous and Mental Disease Publishing Co., Washington, 1934.

their parents and other adults may need the restraint and routine of institutional life. Children, particularly adolescents, who need to be removed from their home environments but for various reasons are liable to fail in foster home adjustment, will need institutional placement. For example, sometimes it is necessary to remove a child from his home, but the emotional bond between the child and his family is so strong that foster home placement represents too strong a threat to this bond. If this is the case, adjustment is more likely to be satisfactory in an institution. It is better that the child should have the security given him by an institution rather than be disturbed by passing through a series of foster homes. For older delinquents the institution may be the only possible place where treatment can be undertaken. Even though no direct treatment of the problems of the child may be attempted, and nothing more is done beyond removing him from his present environment, this in itself may be sufficient to overcome problems that may not have responded to direct treatment while the child remained in the old environment.

## The Foster Home.

Where environmental influences are such that the removal of the child is indicated foster home placement is gaining in favour as preferable to institutional care. If the child's membership in the various social groups in his environment, the family, play groups, gangs, and so on, plays such a large part in determining personality and behaviour, where these are

unsatisfactory, it is to be expected that they will improve if the child is placed in a situation where the groups to which he belongs are more favourable to normal development. This is the purpose of foster home placement, to substitute a healthy family and environmental situation for one that has exercised a deleterious influence. The advantage that the foster home has over the institution is that it provides a much more normal milieu for the child, providing as it does family life in the community where the child has to learn how to live.

Foster home placement is most often employed when the child is in a home that does not give the necessary security, affection, oversight, guidance, and opportunity for the normal growth of personality. Thus the majority of children placed in foster homes come from broken and irregular homes, homes where the parents are divorced, separated, or unable to provide the right home atmosphere for the child because of drunkenness, immorality, or criminal activities. Sometimes because of sickness or extreme poverty the parents are unable to support the child and request foster home placement. Occasionally the home is satisfactory but the neighbourhood influences so bad that transferring the child to a foster home in an entirely new locality is warranted. Usually the more serious problem children, delinquents and those in whom there are sex difficulties, present such great risks in foster home placement that institutionalizing is an easier procedure. Nevertheless, an experimental study carried out by Healy has shown that cases

previously considered unsuitable for foster home treatment can be successfully placed. Of 501 children placed in foster homes, 51 per cent were court delinquents, an exceptionally high percentage justified by the results, as over 70 per cent of these delinquents responded successfully to placement. Of the non-delinquent children in the total group, success was reported in 90 per cent of the cases.[9]

Though the selection of cases which will respond to foster home placement is often a difficult matter, the choice of foster homes for them is even more difficult. Originally when foster homes were used mainly for orphan and deserted children insufficient attention was given to the type of home taking the child, but with the increasing use of foster homes for problem children standards for foster homes have become much stricter. While the foster home must maintain certain standards of economic stability, cleanliness, physical comfort, suitability of locality, proximity to school and companions, of greater importance are the attitudes displayed by the foster parents and any other children in the home.

Dr. C. R. Rogers has given the following attitudes as essential in any foster home:

a. An attitude of intelligent understanding, the ability to accept the child's behaviour without being shocked and given to moralizing.

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[9] Healy, William, et. al., Reconstructing behaviour in youth, New York, Knopf Inc., 1929.

b. A consistency of point of view and discipline, a stable atmosphere enabling the child to feel secure. This is essential in any home and it is because this has been lacking in his own home that the child is placed in the foster home.

c. An attitude of interested affection. Not the over-powering affection of the emotionally starved adult, but a steady, helpful affection.

d. Satisfaction in the child's developing abilities however modest.[10]

Care must be taken to see that the foster parents are really interested in the child for his own sake, and not as a solution to emotional problems of their own. Thus a mother who has rejected her own child and then to appease her guilt feelings decides to adopt a child is not likely to be a desirable foster parent.

The placement of a child in the right foster home is a task requiring time and skill. When a suitable home has been found a careful study is undertaken to guarantee that the home is one appropriate to the particular child in question, then the placement must be interpreted to the child, the parents and foster parents. After placement by the clinic or social service agency continued assistance and advice concerning the adjustments involved for all concerned are necessary. If the

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[10] Rogers, C. R., The clinical treatment of the problem child, Houghton Mifflin Co., 1939, p. 74.

placement is not to be permanent and the child is to be returned to his own home when the cause of the change has been removed, the child, foster parents and natural parents must be prepared for the later change. The removing of a child from his home and parents, his acceptance of and by the parent-substitutes, and sometimes the breaking of the second relationship and the re-establishing of the original one, are all actions fraught with emotional difficulties for both the child and the adults. It is likely that a great deal of light will be thrown on this whole question by the experience being gained in Britain with the evacuation of large sections of the child population from the cities during the war, and the billeting of these children with strange families in quite new surroundings.[11]

If the child's own home is such that radical changes necessary for the child's normal development cannot be effected, placement in a foster home, provided that a suitable one can be found, will be in many cases the immediate and most practical therapeutic procedure. It is often futile to waste time with intensive, direct therapy if the existing family situation makes successful adjustment impossible for the child. It is surprising how really serious behaviour problems will clear up without any specific treatment if the child is placed in

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11 Strachey, St. Loe, Borrowed children, Commonwealth Fund, New York, 1940.

a stable foster home that gives the needed security and affection. However in many cases direct therapy should be combined with the foster home placement, though this presents certain technical psychotherapeutic problems that cannot be gone into here.

Manipulating the Environment.

In almost every case coming to the child guidance clinic for treatment some environmental manipulation is necessary as part at least of the treatment programme. We have seen that in extreme cases this means actually changing completely the home situation and the environment, but in the majority of instances this drastic measure is not indicated as it is possible to achieve the desired results by changing prejudicial environmental factors. This may not be dignified by any high-sounding name and may lack the fascination of more elaborate therapeutic techniques, but none the less may often be quite effective.

Sometimes simply changing a school teacher, class or school will effect immediate modification in a child's behaviour patterns. Delinquent behaviour may be due to a lack of recreational facilities and opportunities for adventure, the provision of which by the school, home or some club, scout troop or similar organization, may remove the behaviour problems by removing their cause. As the source of much trouble is in the attitudes and behaviour of those in the most close relationship to the child, the parents, they represent a major

point of attack in the treatment. Work with parents has become so significant for child guidance that separate discussion of it is needed.

As everything in the environment contributes, however indirectly, to the personality development and behaviour of the child any change in the environment will mean something for him. A change that may seem very trivial and inconsequential to the adult may be of utmost significance for the child who invests things with idiomatic meaning unknown to the adult. This does not mean that all obstacles and frustrating influences must be removed or modified as some parents foolishly think; on the contrary some children suffer through the absence of challenging situations. Rules for environmental manipulation cannot be laid down; what should be done depends on the type of problem and the entire situation of child-and-environment, the dynamics of the social field.

### Treatment of Parents.

No proof is required of the fact that the most influential relationship in the life of the child is that with the parents, a fact accepted and acted on from earliest times. However it is only in recent years that the subtilty and peculiar dynamics of the parent-child relationship have been understood, though such understanding as we now have is still far from complete. For good or ill the parents are major factors in the total field which determines the personality, behaviour and future development of the child. This being so, it is obvious that

if a child manifests behaviour problems the clue to them will probably be found in the nature of the relationship existing between the child and his parents. Thus treatment of the problem child usually involves effecting alteration or elimination of certain attitudes and behaviour in either one or both parents. The need for this has been recognized by child guidance workers from the beginning.

At first workers attempted to correct parental attitudes by didactic methods. Parents were advised of their mistakes and instructed in the principles of bringing up children, often being given specific instruction on what they should do. At the same time attention was directed toward courses in parent education and allied subjects. Experience soon showed however that these didactic methods were not meeting with the success hoped for, and necessary, if children and parents were to be helped. The reason for this failure was that most problem children had problem parents who were so deeply involved emotionally in the situation that they would not or could not accept the advice and information meted out. Consequently new techniques had to be evolved.

The techniques that have been developed to deal with parents in the child guidance clinic are largely the result of the organization of the clinic. As it was the psychiatric social worker who usually interviewed the parents while the psychiatrist and psychologist worked with the child, it naturally fell to her to continue interviewing the parent or

parents in what frequently became a therapeutic relationship. Certain limitations on the therapy to be employed with parents must be noted: as the chief concern of the child guidance clinic is with the child only such therapy should be undertaken with the adult as is necessary for the successful treatment of the child; owing to the limited training of most social workers in psychiatry and psychotherapy they are not qualified to give treatment involving the deeper and more complicated levels of the personality. Consequently the techniques developed had to meet the practical demands of the child guidance programme. Three techniques for dealing with parents have been distinguished in the literature, and though they have much in common it is convenient to discuss them separately.

As mentioned earlier ( page 133 ), relationship therapy originated in the Pennsylvania School of Social Work, and was given publicity by Jessie Taft in her book, The Dynamics of Therapy, in which the technique is discussed in relation to children.[12] The essential feature of relationship therapy is that the worker endeavors to provide an atmosphere in which the parent can freely express his or her feelings without fear of criticism or condemnation. The worker maintains a friendly but impart-

[12]Taft, Jessie. A dynamics of therapy. Macmillian, New York, 1933.

ial and objective attitude, a kind of sympathetic neutrality, which enables the patient to unburden feelings and attitudes concerning not only the child, but also the parent's adjustment in other areas of life. On the whole the worker plays a passive role, though not necessarily an impassive one. The goal of such therapy is to assist the parent to an acceptance of the self by a clarification of the feelings through expressing them, and so achieve insight that will make possible normal adjustment and personality development.

This technique which is used with children as well as adults is not as simple as it may seem. Many people expect positive advice and do not readily accept the passive role of the worker. The extent to which the worker can be active is a constant problem, particularly if the treatment process does not appear to be progressing rapidly enough. For some people with little capacity for insight, relationship therapy may be a long and perhaps unsuccessful venture. Two things in favour of relationship therapy are that it stresses the worker-client relationship that is present in every therapeutic situation, and it recognizes the integrity and inviolability of the personality of the patient and client.

A very similar treatment approach is one that has been labelled "passive" therapy, a reaction to the more authoritative, didactic methods in which the worker tended to impose his attitudes and beliefs upon the client. The term has been bandied about to apply to the attitude of the therapist in a variety of therapeutic relationships rather than

denoting any particular technique. So far as one can speak of passive therapy as such, it refers to the treatment procedure when the initiative is taken by the client to begin, maintain and conclude the therapeutic relationship. In passive therapy, the nature of the material discussed and the progress of the interviews depend on the felt needs of the client and not on the therapeutic objectives of the therapist.

Although there was probably a need for emphasis on the avoidance by the therapist of dictatorial and aggressive attitudes, and the need for a greater recognition of the rights of the client in the therapeutic relationship, the discussion as to whether therapy should be passive or active tended to confuse the real issues. Actually no therapist can be entirely passive, and the attempt to be consistently passive would certainly interfere with the building up of rapport essential in every therapeutic situation. As Dr. Lawson G. Lowrey has pointed out, "passive" and " active" are merely relative terms referring to different facets of the relationship involved in therapy.[13] The value of the discussions on the passivity and activity of the therapist is that they force those engaged in therapy to consider closely what is actually going on as a result of the relationship established in their contacts with the client.

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[13] Lowrey, Lawson G. Trends in therapy. American Journal of Orthopsychiatry, 1939, 9: 691.

Attitude therapy was developed by Dr. David Levy at the Institute for Child Guidance, New York, and was a technique designed specifically for the social worker working under the direction of a psychiatrist.[14] It got its name from its objectives, the clarification and, as necessary, the modification of parental attitudes prejudicial to the best interests of the child. The process naturally demanded a therapeutic relationship over a considerable period, with regular interviews covering a great deal of material at varying levels, though stopping short of the deeper mechanisms dealt with in psycho-analysis.

Indications for the use of this method have been summarized as follows:

i. That the mother herself desired continued contacts with the worker.

ii. That a change in the mother's own attitudes was essential to the welfare of the child.

iii. That further beneficial effects would not be likely by a continued use of other social treatment methods.

iv. That the mother was believed by the psychiatrist to be suitable for this intensive kind of treatment without incurring risks.

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[14] Levy, David M. "Attitude therapy." American Journal of Orthopsychiatry, 1937, 7: 103-113.

v. That thus limiting the social worker's contacts to the mother was not incompatible with the social service needs of the case as a whole.[15]

This summary raises points important not only for the conduct of attitude therapy, but which are relevant to any form of treatment undertaken with parents of children brought to the clinic. Treatment of parents should only by given if it is necessary in the interests of the child; such treatment should by supervised by the psychiatrist and should guard against raising therapeutic problems beyond the scope of the worker; it should only be engaged in when methods requiring less time are of no avail; the parent must desire treatment for his own sake; the primary responsibility of the child guidance clinic is the child, so that no activity should be conducted if it is liable to interfere with the satisfactory prosecution of work with the child.

Whatever attitude one might adopt toward these particular methods, it is quite certain that in the great majority of cases dealt with in the child guidance clinic work with the parents is desirable and frequently of basic importance. Of all the forms of environmental manipulation as part of the general treatment programme, dealing with parental attitudes and behavior is the most urgent, and if successfully carried through may contribute more than anything else to overcoming the child's problem.

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[15] Quoted by Stevenson and Smith in Child Guidance Clinics (page 93) from a paper by Katherine Moore: A specialized method in the treatment of parents in a child guidance clinic.

In practice, it is often impossible to work intensively with both parents even if the clinic staff were adequate to cope with such a situation. The employment of the father usually prevents any regular interviewing during clinic hours, so that, as can be noticed in the case discussions reported in the literature, treatment of parental attitudes must generally be done through the mother. In any case if it were necessary to choose between the parents in the treatment programme, the mother would be the one most likely chosen because of her greater opportunity for influencing the child. However, even though the father may not take an active place in the clinic programme, his cooperation should be sought so that he is fully aware of what is being done. To neglect either parent is liable to lead to serious misunderstandings inimical to treatment objectives.

To some the careful defining and elaborating of procedures to be used with parents may seem so much hair-splitting and needless technical talk. This is a mistaken and rather ignorant attitude. Whether or not we put labels on the methods we use in working with parents, it is necessary that we have methods, and be fully cognizant of the processes involved in these methods. No therapeutic situation should be blundered into without a definite understanding on the part of the worker of what can be accomplished and how in the particular case this should be attempted. In work with the parents, as in any other kind of therapy, training and technical skill are

indispensable qualifications for the worker.

### 3. Direct Therapies

Once again it must be emphasized that the distinction made here between indirect and direct therapies is purely superficial and arbitrary. If we accept an organismic or field theoretical approach to personality and behaviour, treatment must be directed to both the child and his environment, both are equally important and from the point of view of the case as a whole both are direct treatments.[16] However for convenience we may speak of treatment as direct or indirect according to the immediate point of attack, that is whether it be the child or the environment. We have discussed the environmental approach, now we shall discuss the therapeutic approach to the child as such. The order in which various therapies are discussed is simply a matter of method and does not indicate their relative importance.

#### Physical Therapy.

It is quite obvious that any physical disorders discovered in the diagnostic medical examination or developing during treatment should be given the appropriate attention. Such matters as diet, sleeping conditions, and the amount of play and exercise should be carefully investigated. If the child

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[16] This approach to therapy is clearly demonstrated in a book by William Healy and Augusta Bronner: New Light on delinquency and its treatment. Yale University Press, 1936.

suffers from malnutrition, insufficient sleep or sleep that is disturbed by the presence of adults and noise, over-excitement and fatigue or lack of healthy exercise, behaviour disorders are to be expected and will not respond satisfactorily to treatment unless these provoking factors are dealt with.

Then there are various physical conditions which, if not entirely responsible for, may be contributing causal agents in the behaviour syndrome requiring attention. Children suffering from gross physical handicaps such as faulty vision, deafness, bodily deformities or abnormalities, often are at a disadvantage in competition with other children and can readily develop feelings of inferiority and insecurity, for which they may overcompensate by aggressive and other troublesome behaviour. Sometimes a child may have some slight physical peculiarity known to no one outside his family, yet the very fact of this difference may influence his conduct to an extraordinary degree. Children hate to be different from their fellows and may suffer keenly from the comparisons and comments that are made concerning any differences. Boys are particularly sensitive to any unusual sex features and to any retardation of sexual development. Where possible the physical abnormality should be corrected; if this cannot be done the child should be helped to accept and to adjust his limitations.

The association of tonsillar trouble and adenoid growths with retardation in school and general difficulties of personal and social adjustment has long been recognized. Neurological conditions that are often difficult to locate and equally difficult to treat are sometimes responsible for personality and conduct abnormalities, as in encephalitis lethargica. In recent years considerable attention has been devoted to endocrine dysfunctions and accompanying metabolic disturbances, and while claims that all behaviour and personality deviations are attributable to endocrine disorders, undoubtedly in some cases as in hypothyroidism and hypopituitarism endocrine therapy will result in marked personality changes.

In all physical therapy the physician should try to discover whether the condition being treated is a primary cause of the personality problem or a symptom of a deeper, more fundamental difficulty, though as a symptom it may also exercise a secondary causal efficacy. It should be remembered that as all physical conditions exist in a person who is a body-mind unity, treatment of a physical condition will produce mental as well as physical effects, and treatment of mental states will produce physical as well as mental effects. Moreover, as all physical therapy involves a personal relationship between the physician and the child, this in itself partakes of the nature of a psychotherapeutic situation. In other words, however strictly physical a condition may appear, it

should not be regarded in abstraction from the person as a functioning whole; all treatment must be directed toward adjusting the whole person.

At what stage in the treatment programme physical therapy should be undertaken depends on the individual case. Sometimes psychotherapy is futile until serious physical conditions have been dealt with; in others the immediate treatment of the physical condition may upset the child for subsequent psychotherapy. Children brought to the child guidance clinic have often had traumatic experiences associated with doctors and hospitals, so that even the sight of a white coat will disturb them. Consequently even the routine physical examination may need to be postponed until the child's confidence and co-operation have been firmly established. Here again we see an illustration of the need for the closest so-operation between the physician or psychiatrist and the other members of the clinic staff.

## Tutoring Therapy

Frequently difficulties in school adjustment are associated with personality problems. A child who is insecure and unhappy in the home may carry these attitudes over into the school situation in which teachers a re identified with the parents, resulting in poor school work, perhaps even marked scholastic retardation. On the other hand sometimes through a specific defect or through frequent changing of schools the child may become backward in some if not all the school subjects, and so lose interest and become dissatisfied

troublesome, perhaps delinquent. Thus we get a vicious circle of personality problems and educational failure. Tutoring therapy is one attempt to break this vicious circle.

In cases when school adjustment is unsatisfactory because of backwardness tutoring may be the immediate and major treatment measure. But before tutoring is commenced a preliminary period should be spent in building up the child's confidence and belief that he can succeed, as Dr. William Moodie has stressed, "it is usually rather risky to attempt to make up a serious educational backwardness without this preliminary building up of the feeling of capacity."[17] Grace Arthur has reported a series of cases in which tutoring therapy not only corrected the educational deficiencies and school maladjustment, but also resulted in a general improvement in the social adjustment.[18] It must be remembered that whatever the tutoring may be, whether in reading, spelling, arithmetic, writing or any other subject or group of subjects, in addition to the value of the tutoring itself, a relationship is developed which is psychotherapeutic.

In cases when the educational backwardness is secondary to the personality difficulties direct psychotherapeutic techniques should be first employed. Sometimes without any

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17 Moodie, William. The doctor and the difficult child. Commonwealth Fund, New York, 1940, p. 55.

18 Arthur, Grace. "Tutoring as therapy." American Journal of Orthopsychiatry, 1939, 9:179 ff.

special coaching the school difficulties will clear up with the progress of the therapy, but when the backwardness is very great tutoring will be necessary and should be given at a time when the child can best benefit from it.

Tutoring should never be delegated to the child's parents even though they may be anxious to give this assistance. Backward children have usually been subjected to parental pressures before coming to the clinic, and it is difficult for both parents and children to enter the coaching situation free from prejudices and attitudes militating against success. Since the clinic psychologist usually does not have the time to devote to tutorial work, it is often done by outside assistants qualified in this field. When outside tutors are employed care should be taken to see that they understand the therapeutic nature of their work and appreciate its place in the wider clinic programme.

Speech difficulties call for special consideration.[19] While many speech defects and disturbances are the result of psychogenic, neurophysiological and anatomical conditions requiring direct treatment by psychotherapy, surgery and other special means, a sufficient number of speech disorders are seen in clinics in which remedial speech training is indicated, that the employment of a speech therapist is desirable. As with the other problems mentioned, speech difficulties involve the whole personality, hence the need for the remedial

[19] A good text dealing with speech difficulties, their diagnosis and treatment, is that of West, Kennedy and Carr: The rehabilitation of speech. Harper & Brothers, New York, 1937.

work of the speech therapist to be integrated with the rest of the clinic activity.

Therapeutic Conversations.

Under this general heading can be grouped a number of procedures that have been given various labels: suggestion therapy, relationship therapy, supportive therapy, re-education. Although some of these therapeutic approaches have been more developed than others, and technical distinctions can be made between them, they are all based on the same principle. The purpose of all these techniques is to provide the insecure and troubled child with an unemotional, uncritical, understanding relationship with an adult divested of the authority and power of the parent or teacher.

Some cases in which the problem is not deep-rooted will respond to a matter-of-fact discussion of the problem, accepting the advice and suggestions of the therapist. Sometimes children have come into conflict with the law and are brought to the clinic as delinquents when the cause of the trouble is nothing more than ignorance of the law or lack of appreciation of the consequences of their behaviour. Children with sex problems may only be in need of straightforward sex instruction, hence a frank discussion of their problems with a sympathetic, non-moralistic adult will free them of their doubts and difficulties. Of course, when the problems are of a serious nature treatment by means of therapeutic consult-

ations in which suggestion and direct instruction are employed, may not only fail to effect a cure, it may be actually harmful.

Particularly in older children of sufficient intelligence therapeutic conversations may be directed toward giving the child insight into his attitudes and the causes of his behaviour. Insight therapy as such is limited to the investigation and interpretation of the meanings of the patient's attitudes and behaviour.[20] Attitude therapy goes further as it consists of three major processes: "exploration of the typical emotional trends, release of tension and painful over-weighted feeling, and interpretation of the patient's feelings."[21] Insight and attitude therapies in that they work at a deeper level than suggestion and consultation therapies require a longer term of treatment. If attitudes are revealed and tensions released too precipitously, at a rate or extent beyond the capacity of the patient to accept them, further anxieties and tensions will be created.

In relationship and supportive therapy the emphasis is on establishing a patient-therapist situation in which the patient feels perfectly free to discuss his feelings and

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20 Levy, David M. "Symposium on treatment." American Journal of Orthopsychiatry, 1940, 10:695.

21 Moore, Madeline U. "Symposium on treatment." American Journal of Orthopsychiatry, 1940, 10:690.

ideas without fear of ridicule or censure, an atmosphere conducive to self-realization and personality growth. As indicated earlier (pages 217-218) in relationship therapy the stress is on the neutrality and passivity of the worker. In supportive therapy the worker takes a more active role. "Supportive therapy is the conscious attempt to mitigate the child's affect hunger through a strong emotional tie to the case worker; a deliberate giving of affection and interest which is not a means of strengthening therapy, but is in itself the therapy."[22] Naturally these techniques demand skilful handling of the rapport and transference that are developed. In relationship therapy this problem is largely solved by the patient, but in the more positive transference basic to supportive therapy greater effort on the part of the therapist is needed during the closing phases of therapy.

Re-education takes place during the conduct of all psychotherapy, being the property of not any one technique alone. As a result of therapeutic conversations, whatever special technique is employed, the child gains increased understanding of himself and his place in the home, school and community. This re-education is not simply an intellectual matter, for it involves the child as a growing, feeling, willing, thinking personality as part of a particular environmental situation.

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22 Axelrode, Jeanette. "Some indications for supportive therapy." American Journal of Orthopsychiatry, 1940, 10:265.

## Release Therapies.

The value of releasing tensions by means of abreaction or catharsis has long been recognized both by the lay public and by psychotherapists. People feel better after they have "got something off their chest," "told somebody what they thought of them," in some way unburdened themselves to an audience, however unappreciative. Thus in London during the first months of air-raids in the present war men could be seen walking the streets wearing notices "Listern to your air-raid story for a penny," commercializing the idea that the Church has used for centuries in the practice of the confessional.

For children the natural means of expression of tensions is through play and free activity, and it is on this principle that Dr. David M. Levy developed the technique generally known as release therapy.[23] Usually the therapist chooses the material for the play and suggests a possible scene or plot. Thus in the case of a child with intense sibling rivalry that cannot be expressed the material may be a family of small dolls, preferably ones that can be dismembered and put together again at will. The child is encouraged to express through play the feelings that in the ordinary social situation must be repressed;

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[23] Levy, David M. Studies in sibling rivalry. Monograph No. 2. American Orthopsychiatric Association Series.
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the play may or may not be interpreted to the child. It is the acting-out of fears, anxieties, and other tensions, rather than the interpretation and understanding of them that is the foundation of release therapy.

Levy has given the following criteria for selecting children for this form of therapy: "(1) the presenting problem should be a definite symptom picture, precipitated by a specific event, in the form of a frightening experience, the birth of a younger sibling, the discharge of a governess, divorce of the parents, or the like. (2) The problems should not be of too long duration. The children are preferably 10 years old or younger. . . . (3) Regardless of the age at the time of referral and the specificity of the problem, it is important that the child is suffering from something that has happened in the past and not from a difficult situation going on at the time of treatment."[24]

The type of problem for which this technique may be used can be seen from Levy's report of 35 cases, all but 3 of whom responded successfully to treatment: 11 were referred primarily because of night terrors and fears, 5 for tics, 6 for speech disturbances, 4 for temper tantrums or negativism, 3 for refusal to accept femininity, and 1 each for hyperkinesis, nocturnal enuresis, inhibited behaviour, reading difficulty, epilepsy and dementia.[25] Levy is careful to point out that

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[24] Levy, David M. "Release therapy." American Journal of Orthopsychiatry, 1939, 9:715.

[25] Ibid.

sometimes release therapy should be accompanied by other forms of therapy, and that there can be no pat therapeutic formulae; each case must be considered as an individual therapeutic problem.

A form of group release therapy has been developed by Bender and Woltmann at Bellevue Hospital, New York, the puppet show.[26] Puppet plays built around the German folk tradition of Casper and the witch are staged by means of hand-operated puppets, such themes as sibling rivalry, parent-child relations, good and bad parents being worked through. The puppeteer and staff in the audience carefully watch the reactions of the children who are encouraged to cheer, abuse the puppets, and generally give vent to their feelings. At critical stages the puppeteer stops the action, and from behind the curtain calls for suggestions for what should happen next. Eventually the action is brought to a happy and acceptable conclusion. If a child is frightened by the action he is immediately taken behind the scenes and reassured by seeing that the puppets are just dolls manipulated by a person he knows and trusts. During succeeding days the puppet shows are discussed with the children, sometimes with limited interpretation, and the children are given opportunities to make and stage puppet shows of their own.

An experienced puppeteer is essential, and careful ob-

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[26] Bender, Lauretta, and Woltmann, A. G. "The use of puppet shows as a psychotherapeutic method for behaviour problems in children." American Journal of Orthopsychiatry, 1936, 6:341-354.

servation of the children is needed so that the best diagnostic and therapeutic use may be made of the behaviour displayed, and in order that the situation may be kept well under control. It is difficult to evaluate accurately the success of this technique, but observation certainly shows that the children identify themselves with the puppets and do release much pent up hostility, aggression and fear. Moreover there seems to be value in the fact of the group experience; to find that other children hate and fear helps to relieve anxiety and guilt feelings. The follow up of the puppet show by discussion and small shows staged by the children for their own amusement is undoubtedly therapeutically valuable. Thus a boy who had been hysterically mute for some months was able to begin talking through the impersonal medium of the puppet he was operating. The puppet show can most easily be conducted in an institution or hospital where there is a constant group of children, although it could be adapted to the needs of the clinic working with large numbers of children who could meet a day a week for this group activity.

Play acting by small groups of children offers a similar opportunity for the release of tensions and the expression of feelings and attitudes. In this therapeutic medium as with puppet shows, in addition to the release of tensions it is possible to suggest through the play possible constructive solutions to the problems of the individual. The use of

play acting has been elaborately developed with children and adults by Dr. J. L. Moreno of New York.[27]

The possibilities, values, and technical difficulties of group therapy have yet to be systematically explored. It seems clear that many children will express themselves while members of the group in a manner impossible to obtain in an interview with an adult. In the group situation mechanisms and behaviours are revealed that otherwise would remain hidden. On the other hand it must be remembered that in dealing with problem children in groups considerable difficulties will be encountered and without experienced, expert direction the group therapeutic situation can easily generate attitudes and behaviours quite contrary to the therapeutic objectives.

## Play Techniques.

Mention has already been made of the use of play techniques in diagnosis (chapter V), and in release therapy as developed by Levy. Dr. Joseph C. Solomon, a leading exponent of play therapy, has claimed that the therapeutic value of this technique lies in: "(1) the release of hostility toward parents, siblings etc.; (2) alleviation of guilt feelings;

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27 Moreno, J. L. "Psychodramatic shock therapy: a sociometric approach to the problems of mental disorders." Sociometry, 1939, 2:1-30.
------ ----. "Psychodramatic treatment of psychoses." Sociometry, 1940, 3:115-132.

(3) opportunity to express freely all love fantasies; (4) incorporation of therapeutic suggestions in direction of growth; (5) desensitization by means of repetition."[28] All play therapists agree that these therapeutic objectives are attained not so much because of the play itself or the actual content of the play interview, but rather because of the relationship that the play interview establishes between the child and the therapist. Here once again we see the emphasis not on the modus operandi of the technique, but on the inter-personal relationship that is basic to all psychotherapy.

The choice of material for the play interview varies somewhat according to the age and problems of the child, and the preferences of the therapist. In general the idea is to place the child in a situation where there is some variety of play material that may easily be used by the child to express himself: dolls that represent the family, toy furniture such as tables and chairs, a bed, bath, toilet and so on, water pistols, guns, cannons, trains, motor-cars, clay, pencil and paper, crayons, finger paints, perhaps some toys or games requiring the child to seek the co-operation of the therapist. Some therapists prefer to use a standard collection of toys so that they can more readily distinguish the

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[28] Solomon, Joseph C. "Active play therapy: further experiences." American Journal of Orthopsychiatry, 1940, 10:763.

individual differences in the children's choice of material and what they do with it. Others freely experiment with various kinds of play material.

The play interview can be conducted according to various techniques ranging from the passive, inactive role on the part of the therapist to a relationship in which the therapist is an active, directing participant. No one method is to be preferred to the others; the choice of technique depends on the nature of the problem being treated and the training and experience of the therapist.

In the simplest form of play interview the child is left entirely free in the choice of material and play, the therapist merely observing the play without comment or interference. The therapist is a passive spectator to the spontaneous, free activity of the child. This is a useful diagnostic method, and may be therapeutically adequate for the type of problem referred to in the discussion of release therapy.

The element of control is introduced when the therapist selects the play material and suggests possible themes for expression. Thus the child's attention may be directed toward the dolls which are identified as a father, mother, boy, girl and baby, the suggestion being made that perhaps the child might like to make up a story about the family represented by the dolls and act it out with them. From time to time the therapist may ask questions, and give inter-

pretative suggestions of a vague, tentative nature. Thus this method aims not only at giving the child an opportunity to express hostilities and relieve guilt feelings, but also to develop insight and to suggest constructive solutions to the problem-situation.

In what has been termed active play therapy the therapist is an active, directing agent.[29] This method can best be explained by a report of part of an interview.

The boy is taken over to the table and the father, mother and boy dolls pointed out. "Asked who else was in the family, he said a little sister. Asked whom he likes better, he said his mother. Examiner asked him if he thought that was right. Answered he thought it very wrong, boys should not be mad with their fathers. Was told there are a lot of boys who are. When asked how he feels when something happens to the mother, he said, "very sad."
Q- Does he think it is anybody's fault?
A- No, he doesn't think it is anybody's fault because the mother is in the hospital.
Q- How does the boy feel now?
A- He feels good with the father now, he has to be with him because mother is away.
When asked who was going to take the mother's place, he said, "an aunt". Examiner took a doll representing the aunt and asked how the boy liked her. He said he liked her, but liked the mother better.
Q- How about the father?
A- He likes the father now because he doesn't have the mother any more.
Q- How does the boy feel when he goes to bed at night? (Examiner placed the boy doll in bed.)
A- He feels all right.
Q- Does he ever have any dreams?
A- No.

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29 Active play therapy is discussed in the following articles:
Conn, Jacob H. "The child reveals himself through play." Mental Hygiene, 1939, 23:49-69.
Solomon, Joseph C. "Active play therapy." American Journal of Orthopsychiatry, 1938, 8:479.
Symposium. "Play therapy." American Journal of Orthopsychiatry, 1938, 8:499-526.

Examiner suggested that the reason he doesn't have any dreams is that he doesn't want examiner to know who the boy is. He smiled and said that was right. Examiner said that means he was not telling the truth, which he admitted.
Q- Well, does he have dreams?
A- Yes, he has dreams, scary one of ghosts.
Examiner supplied the ghost and asked him to tell one of the dreams. He dreams the ghost is going to chase him down the street. Showed ghost chasing boy."[30]

As this excerpt demonstrates, in active play therapy the initiative for the direction and nature of the play rests with the therapist, who must exercise considerable skill both in the manipulation of the action and the accompanying interpretation. Premature interpretation may provoke anxieties or resistance; inaccurate interpretation may suggest acceptable explanations to the child that have no place in reality. However no therapeutic method is entirely free from risks and from the possibility of misuse in the hands of incompetent workers, and although much has yet to be learnt about the theory and application of active play therapy, sufficient evidence has already been shown of its very great value as a therapeutic instrument. To those who doubt the value of play techniques and discredit the reports made concerning them, the final answer is to try them and see.

Psycho-analysis.

Psycho-analytic therapy in child guidance has several

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[30] Solomon, Joseph C. "Active play therapy: further experiences." American Journal of Orthopsychiatry, 1940, 10:767.

serious disadvantages not shared by the techniques reviewed above. First, there is the matter of the qualifications of the therapist. In order to engage in psycho-analysis one must be an approved trained analyst, which requires a medical degree, four years of training with personal analysis at a psycho-analytic institute, and an additional year of training if child analysis is to be practised.[31] Thus only a very few child guidance workers will be able to obtain the training necessary for psycho-analytic practice. The second major difficulty with psycho-analysis is that with serious cases treatment extends from eighteen to thirty-six months, a severe limitation on the number of cases that can be carried at one time.

Thus whether or not all children would benefit from psycho-analysis, as is sometimes asserted, in actual practice it will be the therapy of choice only in a very limited number of cases. One analyst has clearly indicated the position as follows: "The analysis of children should be limited to those suffering from severe neuroses. Perhaps for the time being it may be well to limit this still further to those children who have failed to respond to general measures, such as lessening the emotional tension surrounding the child in the home and in the school; removal from an atmosphere that encourages the continuation of the neurotic pattern, or

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[31] These are the requirements of the British Institute of Psycho-Analysis, London, working in conjunction with the International Psycho-Analytic Training Commission.

lessening the neurosis of the parent."[32]

Child analysis differs from adult analysis in several important features. In addition to the regular technique of the psycho-analytic interview, child analysis makes free use of the play technique which originated in psycho-analysis with the work of Melanie Klein.[33] Under the influence of Anna Freud,[34] child analysts have recognized the need of working with the parents as well as with the child, a departure from the method of adult analysis. A further difference in the two approaches is that in child analysis the analyst plays a more positive role in the re-educating of the patient, and in giving instruction to both the parents and the child concerning subsequent adjustments.

In evaluating the contribution of psycho-analysis to child guidance one should not overlook the fact that psycho-analytic theory has profoundly influenced every aspect of child guidance practice. Child guidance probably more than any other field of work has incorporated much of the psycho-analytic orientation. This is not really surprising, for as

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32 Lippman, Hyman S. "Child analysis." American Journal of Orthopsychiatry, 1939, 9:707.

33 Klein, Melanie. The psycho-analysis of children. New York, W. W. Norton Co., 1932.

34 Freud, Anna. Introduction to the technic of child analysis. Nervous and Mental Disease Publishing Co., Washington, 1928. ----- ----. Introduction to psycho-analysis for teachers. George Allen & Unwin Ltd, London, 1929.

Dr. Lawson G. Lowrey comments, "I am sure that workers with children have been readily receptive to psycho-analytic theory because they saw living evidence of its soundness on all sides."[35] Social case work, diagnostic methods, methods for treating parents, and therapeutic techniques as applied to children all have borrowed extensively from the concepts and practices of psycho-analysis.

The Open Approach.

This method is one that has been confined almost entirely to hospital clinics that combine student instruction with the examination and treatment of patients, a carry over from medical school practice. The child and his parent are interviewed together in front of an audience of students, parents and other interested people. This may seem a rather brutal procedure, but is one that has been used by such distinguished workers as Adler, Aichorn and Lazar in Vienna; Heuyer and Rubinowitz in Paris; Cameron at Guy's Hospital, London; Wile at Mt. Sinai Hospital, New York.

This is a method requiring great care in the selection of cases, and probably can be effectively undertaken only by people of exceptional tact, understanding and experience. As a device for instructing students and the parents of children brought for treatment it is undoubtedly most valuable.

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35 Lowrey, Lawson G. "Trends in therapy." American Journal of Orthopsychiatry, 1939, 9:696.

The interviewing of parent and child together represents a time economy that is an advantage to the hospital clinic that usually carries an almost impossible case load. The group experience that this method involves is frequently a thoroughly desirable therapeutic factor for both the child and his parents. The dangers involved however are against the recommendation of this approach as one for general adoption.

Accurate evaluation of the results of the different therapeutic procedures is very difficult. Inadequate clinic staffs and the removal of families from the district in which a clinic is situated often make the follow-up of cases quite impossible. At present there is no complete agreement as to what constitutes satisfactory adjustment or "cure", partial adjustment, and failure of treatment: consequently comparison between the results of different clinics is necessarily indefinite. After a careful consideration of the studies dealing with this question, Dr. Carl R. Rogers concludes that: "The treatment of problem and difficult children by means of the selective use of a wide variety of therapeutic procedures is effective with three children out of four in restoring them to a moderate community adjustment. There is not . . . any definite proof that one type of organization is more effective in therapy than any other. Such questions must wait for further data."[36] Child guidance workers have a right to

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[36] Rogers, C. R. op. cit., p. 374.

be proud of their achievements, even though there is still much to be done.

## 4. Conclusion.

The foregoing sketch of trends and techniques in child guidance therapy has attempted to indicate the great variety of therapeutic methods that are open to the child guidance worker. This wealth and diversity of procedures make it possible for the psychiatric social worker, psychologist and psychiatrist to share in the treatment programme, choosing their methods to suit the individual case, varying them as changing conditions demand.

Whatever therapy or combination of therapies may be employed - environmental manipulation, treatment of parents, medical care, tutoring, psychotherapy - it should be remembered throughout that these specific techniques are not dealing with isolated, discrete segments of the child's life, but are simply attacking particular aspects of a dynamic, integrated life-situation. Treatment must be directed toward the child and his environment as a whole. Consequently whether we speak of direct or indirect therapies is merely a matter of terminology, for if we adopt the organismic, field theoretical point of view all therapy is direct treatment of some aspect of a unified life-situation.

No hard and fast rules can be laid down for the choice of therapies; their breadth, depth, and duration depend on the individual case and the facilities at the disposal of the

clinic staff. During the last two or three decades tremendous advances have been made in the field of therapy. It is expected that similar advances will be made in the years that lie ahead. Consequently an open mind is an essential possession for every child guidance worker.

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# CHAPTER VII

## LOOKING FORWARD

Child guidance has had a short but remarkable history. Arising out of the need for a scientific attack on the problems of juvenile delinquency, at a time when the relevant scientific disciplines lacked the necessary knowledge and techniques, in less than twenty-five years it has changed its emphasis considerably, it has developed an amazing variety of techniques, and has contributed a great deal to our understanding of human behaviour and personality. In the course of its development child guidance has drawn generously for its personnel, theories and methods, from general medicine, psychiatry, psychology, and social work. The manner in which child guidance has been able to establish a vital co-operative enterprise shared by several professions is an outstanding example of what can be achieved by genuine professional collaboration. If this integration of professional services is sometimes difficult to obtain, it is but an indication of the nature of the obstacles that the general body of child guidance has overcome.

When one considers the history of child guidance, he is not surprised that it should have acquired a strange heterogeneity of concepts. If child guidance had been built upon firmly established sciences with generally accepted theories the task of developing a uniform ideology and method might not have been impossible. Perhaps it is fortunate that this

was not the case. General medicine, the most stable of the sciences basic to child guidance, has been undergoing change due to the advances made in endocrinology and neurology, and due to the increasing recognition being given to a psychosomatic approach to disease. Psychiatry has largely abandoned its sterile classificatory and descriptive framework, and is finding place for more dynamic concepts and explanations. Psychology has been the battleground for eager contestants from associationism, behaviourism, psycho-analysis, the gestalt school, and all the other psychological camps. Social work, as a new professional discipline, has been anxiously feeling its way through all the confusion of theory and practice. Little wonder that child guidance basing itself on sciences so fluid and relatively unstable should have been a rather loose and constantly evolving combination of ideas and techniques.

Although the eclecticism resulting from this confluence of rapidly changing scientific view points may be deplored by the pure theorist, it has probably been a good thing on the whole. The wide divergence of opinion has led to the exploration of a number of quite distinct procedures. The absence of child guidance dogma has given free rein to experimentation and research. Differences of opinion have led to an extremely fruitful cross-fertilization of minds.

However, some may feel, and perhaps with no little justification, that the time is coming when child guidance workers should take stock and sort out the good from the bad,

and that a consistent theory and methodology should be defined. But before such radical action be taken, many of the ideas and techniques as yet in the experimental stage must be allowed to develop, and means must be found to evaluate satisfactorily both these and earlier endeavors.

While the time may not be ripe for a conscious, systematic evaluation and re-statement of child guidance theory and procedure, actually much of this is constantly going on. We have seen that with regard to techniques of investigation and therapy much has been done to clarify objectives and to refine existing methods and to develop more satisfactory new ones. In the field of theory two significant trends can be detected. Psychiatrists, clinical psychologists, and psychiatric social workers have been deeply influenced by the dynamic concepts of psycho-analysis, so that child guidance theory (perhaps one should say theories) has incorporated many of the psycho-analytic terms and a good deal of general psycho-analytic theory. Then as child guidance workers have realized the necessity for seeing the child in relation to his total environmental situation, and consequently have attempted to direct treatment towards both the child and the various forces operating in his life-situation, child guidance theory has gradually moved in the direction of an organismic, field-theoretical point of view.

In addition to a more accurate and systematic formulation of child guidance theory and methodology, what are some of the problems in need of direct attention? One major problem

is the evaluation of results. Clinicians have been so busy with clinic routine that insufficient time has been given to the important matter of determining how successful various methods have been in terms of permanent adjustment. Not only is this a very difficult thing to determine accurately, in many cases the time between treatment and the present status of the case is not long enough for any reliable decision. Comparison of therapeutic methods is difficult, if not impossible; nevertheless some system of control might be devised whereby therapies could be subjected to more direct comparison and evaluation.

Although much has been written concerning the integration of the clinic and the community mental hygiene programme (if such exists), and undoubtedly in many instances excellent co-operation has been developed between the clinic and other agencies, there is still much to be done in defining the role of the clinic in the community and in the effective realization of this role. It may be that the weakness here lies in the community and not in the clinic, and if this be so, the clinic must seek to lead the community into a more vital partnership.

Child guidance has been successful because it has presented the combined efforts of three principal groups of professional workers - psychiatrists, psychologists, social workers. It has neglected for the most part, however, the contribution that could be made by professional sociologists. If the personality of the child is so profoundly influenced by the cultural pattern as has been maintained in this study and as is

generally claimed by guidance workers, there is need for a much better understanding of all the factors operative in the social field. The clinician must understand the dynamics of the cultural scene if he is to understand the dynamics of the individual personality. This is where the sociologist with his special training and knowledge could make a distinctive and valuable contribution.

Finally, what are some of the immediate steps to be taken in child guidance in Australia? The most pressing need is for extension of the present totally inadequate child guidance facilities. This extension will come about only if the general public is convinced of the need for, and the value of, child guidance. If the community can be shown the serious consequences that issue from the dynamics of a rapidly changing cultural pattern, and the almost inevitable maladjustments this produces in many children, then it will see child guidance as at least a partial remedy that must be employed. The taxpayer must be shown that money spent on child guidance represents a wise investment bearing dividends in happy, healthy children, and in a reduction of the number of delinquents, criminals, mentally deranged, and the socially unfit. If professional and lay people alike are convinced of the need for child guidance clinics, government departments and other bodies will be forced to meet their demands.

But child guidance clinics cannot be established without competent staffs. At present training facilities for child guidance psychiatrists, clinical psychologists, and psychiatric

social workers, fall far short of the requirements demanded in Great Britain and the United States. As has been shown in Chapter III, child guidance calls for highly trained personnel, with basic training that can only be given by universities working in conjunction with the appropriate agencies. There is no reason why Australian universities should not give training in child guidance that will compare favourably with the best offered overseas.

Australia can compensate for its late entry into this field by profiting from the extensive experience that has been gained abroad, so that sound foundations of a progressive child guidance service can be securely laid. Australian conditions are sufficiently like those existing in Britain and America for Australia to adopt attitudes and techniques developed in these countries; on the other hand, conditions in Australia and these countries are sufficiently unlike to necessitate the development of child guidance with an Australian flavour, thereby making a definite contribution to child guidance theory and practice and adding to mankind's understanding of itself.

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