THE DEVELOPMENT OF

CHILD GUIDANCE CLINICS

IN THE

UNITED STATES.

1919

BY

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This interest in the behavior and personality of individuals led to the study of the effects of their environment on their development. Early studies noted a lack of interest in the psychological aspect of this development. However, with increased interest in the psychology of the individual, this lack of interest has been replaced by a more comprehensive understanding of the factors influencing behavior. It is clear that the development of children is influenced by their environment, and that the role of the psychologist is to understand these influences and to provide guidance to children and families in their development.
CHAPTER II

INTRODUCTION

Field

Today there is an unprecedented interest in mental health as a factor in the efficiency of an individual. This interest has grown rapidly in the past three decades, and a change has taken place in the attitude of society toward the individual who does not conform to its standards. In place of the old tendency to condemn and punish these individuals, there is an increasing desire to know the cause of their behavior.

This interest in the behavior and personality of individuals led back to the study of the circumstances that surrounded the patient during early childhood and a realization that "if anything goes wrong in the mental life, it is susceptible of modification and readjustment in direct proportion to the youth of the individual. In other words, the earlier that deviations from healthy ways of thinking and feeling can be reached after they have begun to manifest themselves the greater the hope is of bringing them in line with accepted studies."  

* White, Wm. A., "Mental Hygiene of Childhood" Mental Hygiene Bulletin (Reprint) Sept. 1930, p.8
The field of child guidance is recognized as an important aspect of mental hygiene and much attention is being given to it. It is not at all new in recognizing the predominance of parental influence in shaping the life of a child, but it is new in that "it represents an effort to use science in dealing with problems of the child and of his mother and father." Child guidance, however, is by no means a perfected thing. Much has been learned about the fundamental needs of the child but there is still a great deal more to learn.

The first work in this field was conducted along remedial lines, and the first clinics for children were established in connection with juvenile courts and psychopathic hospitals. These clinics dealt with those who were already delinquent or psychopathic. Modern research, however, has taught us that faulty emotional adjustments are not found only among these classes, but among the so-called "normal" classes as well. Obviously, the person who is above the average intellectually, but who is emotionally handicapped by some maladjustment carried over from childhood may do as much or more harm than the one who is definitely psychopathic. These demand the expert attention. Child guidance clinics, therefore, have extended their scope to include all of the children in the community.
and the emphasis is now placed on conserving mental health.

One of the greatest strides forward has been in the realization of this need for the study and understanding of the problems of behavior and personality in their formative stages. The recognition of "childhood as the period of hope and prevention, the period for refinement of the mental fabric" led to child-guidance and the need for the type of service provided by the child guidance clinic. In guiding the normal child as well as the abnormal one, we must first accept the fact that there is a definite cause for behavior, and then try to analyze and understand this cause. "The fundamental conflict is between his (the child's) ego impulses and the demands of the group. Every child is self-centered and profoundly selfish because of his early training. He soon must learn to adjust to the group. If the demands of the group are too hardly forced upon him, he becomes negativistic, antagonistic, bitter, apathetic, his hand against society, or he may have his spirit broken. On the other hand, if he is allowed to have too full play of his ego impulses, he becomes profoundly self-

Stevenson, George S. "The Child-Guidance Clinic: Its Aim, Growth and Methods". p. 2
centered and selfish, demanding his rights at the expense of others also. If we are to understand human behavior, whether it is manifest in the child or in the adult, we must go back and study the individual in relation to the environment in which he has been reared, his past experiences, his reactions to everyday problems, and his general physical and mental make-up.

Much has been written about the general field of child-guidance, and there is increasing interest in it. Many magazines have regular departments on child care, both physical and mental. Some of the larger Sunday papers have sections dealing with this subject and there are several magazines devoted entirely to parent-education. All of these are written by specialists and directed to the intelligent layman. In addition to these, since the beginning of the scientific study of the mental development of children, there have arisen many clinics for the purpose of aiding such children. The number of these has steadily increased and their importance has been more and more recognized in the last few years.

Purpose

In spite of the importance, however, of this movement, and the widespread interest in it, there

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has been no complete publication of the history of the development of child-guidance clinics in the United States. The purpose of this study, therefore, is to present briefly but adequately such a history.

Sources

The material has been gathered from general books on the subject, from magazine articles, reports and pamphlets from individual clinics, and also from pamphlets published by the Commonwealth Fund, and the National Committee for Mental Hygiene. The material was found to be abundant and available, and, therefore, it was not necessary to secure information through correspondence.
PART II.

What is a Child Guidance Clinic?

In order to have a clearer understanding of the subject, it is well to define what is meant by a child-guidance clinic, and to give a statement of its aims and purposes. In the first place these clinics go by a wide variety of names. The most commonly used ones are: child-guidance clinic, institute for juvenile research, bureau of children's guidance, and habit-training clinic. For the sake of convenience, we will use the term child guidance clinic when speaking of general psychiatric clinics for children.

A child-guidance clinic is an organization that seeks to bring to the study, training, and treatment of problem children whatever medicine, psychiatry, psychology, education, and social-case work can offer—In a child-guidance clinic, no part of the study—physical, psychiatric, psychological, educational or social—is separate and distinct unto itself. Each part goes to make up a total and complete picture of the individual child and his adjustments to life. Each contributes to a properly balanced program of treatment. *2* It

*Anderson, V.V. — The Organization and Operation of Child Guidance Clinics —* p. 3
utilizes the services of specialists trained in four different fields to make possible a complete understanding and study of the child's problem. "The clinic treats these problems, not only by treating the child through whom they become overt, but as well the family, school, recreational and other factors and persons which contribute to the problem, and these disorders the problem may really reflect.** It studies and treats the behavior and personality problems of children from pre-school age to adolescence and includes both the inferior and the superior child. Although in most clinics it is necessary to limit the number of cases taken, the ideal clinic should "stand open and ready to study, help and advise in the case of any problem child referred to it, whatever the problem may be. It should offer its services without discrimination, whether the case be that of a child with superior abilities, whose parents wish guidance in maintaining his mental health and mapping out a program for his best development; or a pre-school child who has begun to develop habits that later become injurious to his mental health; or a school child who manifests definite conduct disorders or

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* Stevenson, George S. op.cit. p.1
educational maladjustment; or a child who has developed a mental conflict that later may result in a mental breakdown; or a child whose personality make-up is such as to bring about difficulties in later life; or the ward of a child-placing agency who is to be placed in a foster home; or a child whose delinquency has brought him to the juvenile court."

To speak of "problem children," but what do we mean by this term? Lawson S., Lowery, Director of the Institute for Child Guidance in New York City, says that they are "children whose behavior is out of the ordinary, either because they do unusual or queer things, or because they are overactive, or "nervous," or undisciplined or sociable, or show other disorders of behavior such as anti-social acts. Such behavior may be encountered in children who are superior or even good or inferior in intelligence." Such behavior is an expression of difficulties in social adaptation, and the child who exhibits it may be spoken of as a maladjusted."

The purpose of a child-guidance clinic is

*Anderson, V.V.- op.cit. p.3
**Lowery, Lawson S.- A Child Guidance Clinic p.3
to keep children on the road to useful citizenship, and to lead them to a happier and healthier adjustment in later life. "It does not offer any new, magical way of modifying human behavior, but tries to apply to human behavior the same objective, careful scientific methods that are used in studying the other facts of life. It tries to find out why the child did the thing that he did and then to make such environmental changes, apply such education and moral training, give such emotional re-education as will help the child to adapt himself in a happy and successful way to the social group." Its aim is "a more efficient, more productive, more harmonious adulthood for the children under consideration, and a healthy mental life during their period of development." A clinic is not content with a mere diagnosis. To apply a few tests and then attach some learned label to the child by which he can be pigeon-holed is not sufficient. The task of a child-guidance clinic is three-fold. First, there is the study and treatment of the child with problems; second, the diffusion of a firmer knowledge of mental hygiene and its application through the

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Danton, Sidney - op.cit. p.39

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Stevenson, George S. - op.cit. p.5
fields of education and social work, and through the community at large; and third, research which will add to the fund of scientific facts concerning the behavior and mind of men.

The Clinic studies the whole child bringing to the study all the resources of physical, psychological, psychiatric and social examination and treatment. The social treatment includes, "getting across to the parents the patient’s needs; soliciting their cooperation in fulfilling these needs; helping them work out their own difficulties insofar as these affect the child’s problems; securing community contacts and outlets for the patient; interpreting Clinic recommendations to the schools, the Court, foster and boarding-parents, relatives, and other people who may be instrumental in effecting a readjustment." The type of treatment depends upon the needs of the individual child and may be anything that will help him to make a more satisfactory adjustment. The Clinic does not favor one type of therapy above all others. Child guidance bases its working knowledge on a group of related sciences, but "the gaps have to be cemented with arbitrary, theoretical or logical steps in order to convert the scientific fact into a technique." This movement is still in an experimental stage, and there are no hard and fast rules for treatment. Its theories and

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*Coppell, Harvey H. “Outline of a Practical Child Guidance Clinic” Virginia Medical Monthly, January 1932, pp. 9 & 10 (Reprint)

techniques are being subjected to the hard test of practical application, and though they will not always be successful, we can profit by mistakes and every bit of good advice to the foundation on which future generations can continue to build. We can never formulate final and static rules, however, to cover all mental hygiene issues.

"The problem is not a static one, nor a question of structures to be analyzed; but is a problem in dynamics, in dealing with which we are confronted by constant flux and change." 44

The second task of the Child Guidance Clinic is community education in the mental hygiene of childhood.

"Mental health principles evolved in the study and treatment of the child are passed on to the parents, the school teachers, school nurses, judges, probation officers, the social worker and physician, and by them to other persons in the community." 45

The general aim in the educational program is to bring about the realization of the importance of mental hygiene in the development of the average child and in the life of the average adult. This is attempted by lectures to clubs, study groups, parent-teachers associations, medical associations, and other organizations; by personal contacts; and by written articles for newspapers and magazines.

44 Coghill, Harvie B., op. cit. - p.5
45 Lourey, Lawson C. "A Program for Promoting Mental Hygiene Needs in a City." Child Guidance Clinic and the Community.
The purpose of the work with other agencies is to give them a better understanding of the methods and aims of the child guidance clinic; to help them to adopt a mental hygiene point of view in regard to all cases, and not merely in regard to the obviously abnormal ones; and to aid them in their selection of cases which they refer to the clinic. This program is carried on by the cooperative handling of cases, lecture courses in schools for social work, pamphlets and circular letters explaining the work of the clinic and the problems dealt with.

It has been found by experience that the responsibility for educational work can best be divided among the members of the staff, according to the differences of their experiences. The psychologist, because of his experiences in the field of education and the relationship of the work, can probably make the best contact with the schools. The same is true in regard to the psychiatrist and contacts with the medical profession, and the psychiatric social worker with the social service agencies. Every clinic worker, however, should be able to work with lay groups.

The third task is research. As child-guidance is a cooperatively inter-field, research is needed in the analysis of results, methods of treatment, new developments of theory, and in general psychiatric problems. Research is based upon case records and is "fundamental to the
advancement and knowledge in the child-guidance field. Clinics, however, are equipped primarily to give service to the community, and in spite of the very definite need for careful research, it is necessary in most clinics to leave this part of the program to the initiative of the individual staff members, although a few clinics such as the Institute for Juvenile Research in Chicago and the Institute for Child Guidance in New York are well equipped to carry on a research program along with their other work and include research as a definite motive.

Behavior or personality problems in early years of the child's development are best met within the field of normal hygiene, and since the first chapter of the history of mental hygiene assumes before going on the history of child-guidance clinics.


Hill, Hable B. } "Social Work Year Book - 1930" P. 339
CHAPTER XI.

EARLY HISTORY OF THE GENERAL MENTAL HYGIENE MOVEMENT.

Definition of Mental Hygiene.

Since clinical work with the children who present behavior or personality problems is only one of the many activities that come within the field of mental hygiene, one must first know something of the larger mental hygiene movement before taking up the history of child-guidance clinics.

Frankwood W. Illiams, Medical Director of the National Committee for Mental Hygiene says that "in attempting to define mental hygiene, one must differentiate between (1) mental hygiene as an organized movement and (2) mental hygiene as an art in the application of knowledge derived from certain basic sciences to the maintenance of individual mental health. In the latter sense, mental health should not be interpreted too narrowly as merely freedom from disease, but broadly in the sense of behavior and the ability to attain and maintain
satisfactory human relationships." 

We are chiefly concerned here, however, with mental hygiene as an organized social movement which interests itself in the care and treatment of the mentally ill and the mentally defective; in the stimulation of interest in the value of mental health; and in the relationship between mental disease and social problems such as delinquency, dependency, domestic difficulties, and industrial and social unrest. The importance of the movement lies in "the dissemination of information in order that prejudices and superstitions in regard to mental illnesses may be broken down and a better understanding of the relationship of personal, domestic, and social problems to states of mental health may become more generally understood;" and in the ability to deal with problems in their formative stages before they have gotten completely out of hand. The problems dealt with are "problems of human relationship, of personality, of character, the intricate play of physical, intellectual, and emotional forces within the individual, and the reaction and counter-reaction between this total play

© Williams, Frankwood M. - Mental Hygiene: An Attempt at a Definition - Reprint - Mental Hygiene; July 1927

© Ibid - P.5.
and similarly intricate factors without the individual. These problems have ever lain at the center of things and have throughout time defeated wiser men than we”. Realizing the size and importance of these problems, mental hygienists should not overestimate their abilities to deal with them, and neither should they be discouraged by failures.

**History and Scope of Work.**

The most important stimulus to the development of the organized mental hygiene movement was the publication of Clifford W. Bear's autobiography, *A Mind That Found Itself*, published in 1908 after the author had been in several institutions for the mentally ill. This book aroused a great deal of interest in mental disease, together with personal interviews and letters, led to the establishment of the Connecticut Society for Mental Hygiene, in New Haven, whose original purpose was an effort to bring about reform and to correct abuses in institutions for the insane.

This in turn gave rise to the National Committee for Mental Hygiene which was founded in February, 1909. Mr. Bear became the secretary of the

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*Ibid.*, p. 6
executive committee which office he still holds today. The National program continued along the lines of the state society, specially treating the cases that had already developed. Three years were spent in getting money for the enterprise and in interesting important persons in the program. When active work was begun in 1913 it was necessarily very elementary because no previous experience existed upon which to base plans, since the field was completely a pioneer one. For the first five years, from 1913 to 1917, the committee's program was "largely devoted to the collection of statistics and other data regarding the size of the problem, its nature, and its most vulnerable points for attack." Their first work was making surveys of conditions in institutions for the insane and the feebleminded. Conditions were found to be very bad; and this led to an investigation of existing legislation regarding the mentally ill and mentally defective, and to steps being taken to bring about legislative enactments for better care of these classes. Research projects were conducted to determine the correlation between mental illness and delinquency, and educational activities were undertaken to stimulate the interest of lay groups.

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Hall, Fred S. \{ Hillis, Habel L. \} Social Work Year Book. 1929. p.361
It was soon realized that the program was entirely too large for a national committee without the assistance of local groups and encouragement was given to the establishment of State Mental Hygiene Societies. One by one the states adopted mental health programs until now there are twenty-six such societies in the United States. "Not all are engaged in active work, but all represent nuclei of influential opinion that could be turned to good advantage with little effort." Each state society is financed locally, and is independent, but is affiliated with and works in close harmony with the National Committee. Though each one varies somewhat from the others according to local needs, they are all built on the same general principle and are all striving toward a common goal. The general purposes of the National Committee are stated on the inside cover of their reprints as follows:

"The National Committee for Mental Hygiene, directly and through its affiliated state societies and local committees, works for the conservation of mental health; the reduction and prevention of mental and nervous disorders and defects; the improved care and treatment of those suffering from mental diseases;"  

*ibid* - p. 267.
the special training and supervising of the feebleminded; and the acquisition and dissemination of reliable information on these subjects and on mental factors involved in the problems of education, industry, delinquency, dependency, and others related to the broad field of human behavior. The committee seeks to accomplish its purposes by stimulating research into the nature and causes of nervous and mental diseases and defects; conducting surveys and studies of mental hygiene problems; applying the knowledge gained from such studies, through education and the promotion of beneficial legislation; encouraging psychiatric social work; establishing child-guidance and other mental-hygiene clinics; developing trained personnel; and cooperating with governmental and unofficial agencies whose work touches at any point the field of mental hygiene.

During the World War most civilian mental hygiene work was suspended and attention was diverted to military needs. Mental hygiene projects were undertaken in both the army and the navy. Attention was centered on "shell-shock" and other functional nervous diseases. The war precipitated a change of emphasis from mere classification and custodial care to a vigorous treatment program of psychotherapy, and
after the war this was carried over into larger programs in civilian fields.

The second national organization was founded in Canada in 1913, and "profit[ing] from the ten years experience in mental hygiene in the United States, the Canadian program was from the first a comprehensive one." From then on the number of national agencies for mental hygiene increased steadily, and in 1920 the First International Congress of Mental Hygiene was held in Washington, D.C. At that time their were representatives from almost every country in the world, and an International Committee was formally established.

From the first "the leaders of the movement clearly visualized the functions as extending much farther (than treatment and prevention of mental disease and delinquency); and saw it as concerned with the whole life adjustment of the human individual". One of the first things undertaken was the education of the public. This was done by the distribution of pamphlets, leaflets, and reports on various mental hygiene subjects, and lectures by outstanding persons in the field. In 1917 the quarterly journal Mental Hygiene was first published. The articles in this

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Grosser, Ernest R. "Introduction to Mental Hygiene" P.6
Blanchard, Phyllis

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Ibid- p.7
magazines cover a wide range of topics, they are scientific and yet are written "in a style that is intelligible to the educated layman as well as to professionals."

The mental hygiene program in the last twenty-four years has been greatly broadened to include work in the fields of education, marriage, parenthood, industry, and other fields dealing with the relationships of human individuals. It brings together the fields of psychology, psychiatry, and psycho-analysis, and its "emphasis is placed on the study of the whole organism in relation to its total environmental stimulation."

The National Committee through the programs it has sponsored has been able to interest three great foundations in its work and some of its finest achievements have been made possible through the cooperation of these philanthropic enterprises, namely, the Rockefeller Foundation, the Laura Spellman Memorial Fund, and the Commonwealth Fund.

One of the major activities of the National Committee from the time of its foundation was the stimulation of interest in the establishment of

* Ibid. p.5.
** Ibid. p.28.
psychiatric and mental hygiene clinics. The first clinics were established in connection with psychopathic hospitals and dealt mainly with adults. It was soon recognized, however, that if preventive work was to be effective the clinics must deal with the children as well as adults, because as William White has said, "Childhood is the golden age for mental hygiene". Study of adult problems, whether they are in the field of delinquency, dependency, mental disease, or whatever the field may be, led to the realization that the cause was the individual's inability both during childhood and since childhood to make a satisfactory adjustment to society. Some of these problems have a sudden onset, but they develop over a period of years.

Modern mental hygiene has also taught us that the explanation of delinquency cannot be comprised merely in the term "delinquency". As we have learned more about mental disease and mental defect, we know there are many adult criminals and many juvenile delinquents who are neither feebleminded nor insane, though they may have mental abnormalities which contribute to their antisocial behavior. We know now that before we can make any attempt at social readjustment, we must learn as much as possible about the
type of persons we are dealing with. "We are not dealing with inanimate things or with logical concepts and rigid precedents when we cope with the problem of distorted, crippled, or dangerous humanity. We are concerned with thinking, feeling organisms which cannot be treated according to the laws of physics, the rigid specifications of organization charts, the strict letter of the criminal law."

Glueck, Sheldon: "Mental Hygiene and Crime" P. 28 Psychoanalytic Review
CHAPTER III.

EARLY HISTORY OF CHILD GUIDANCE

CLINICS 1909-1921.

The First Clinic Exclusively for Children.

The first clinic exclusively for children was the Juvenile Psychopathic Institute, organized in Chicago in March 1909, with William Haly, a psychiatrist of broad experience, as Director. It was the only one of its kind in North America, and was "like a lone tree in a barren field. It was observed by every passerby. Many of them hurried and became students of the work." This was a private organization made possible by the beneficence of Mrs. W.P. Drummer, who met the total budget for a period of five years.

The purpose of the organization was to secure studies of the difficult and delinquent children who were brought before the juvenile court, and to recommend and carry out sound treatment for them. It was a remedial agency which concerned itself primarily

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Hunter, Joel B. "History and Development of Institutes for the Study of Children" The Child, The Clinic and the Court, p.804.
with repeated offenders and attempted to prevent further delinquencies.

The Juvenile Psychopathic Institute was the "culmination of ten years of Juvenile Court experience in which the need for more scientific study had been made evident." 

The Juvenile Court was based upon sound psychology—"on the psychology of childhood which teaches that the child and adolescent are not the adult in the small, but have interests, characteristics, and needs of their own." 

Up until the establishment of Court clinics, however, little progress had been made in understanding these characteristics of childhood. Juvenile offenders were given a hearing by a sympathetic judge in special courts and if the offense were not serious enough to warrant punishment, they were probably dismissed with a warning, and further attempts at control by the court were very inadequate. On the other hand, if the offense were serious or vicious, the child was sent to an institution for a period of time. There he was associated with other delinquents, and society was fortunate if he were no worse when he came out than when he went in.

Hall, Prof. B. and Mabel H. op. cit. p. 338

Brenner, Augusta F., "The Contribution of Science to a Program For: Treatment of Juvenile Delinquency." The Child, the Clinic and the Court, p. 75
Hoely is generally credited with the establishment of a new theory—"that the only sound basis for understanding and treatment lies in the study of each delinquent as an individual until the underlying causes of misconduct have been made clear and treatment based on that information has been planned." The value of this individual treatment lies in the ability to establish a connection between the delinquency and the offender's life history, and to understand cause and effect relationship.

The social psychiatrist has also taught us the need of curative rather than punitive measures. We must get away from the idea that severity and punishment alone can stamp out crime. It is evident from the number of repeated offenders that these methods have not been successful, and though our present knowledge of human conduct and its various phases and manifestations is not complete, it is not likely that greater mistakes will be made by basing the treatment on this expanding knowledge, than have already been made by action based on even greater ignorance.

The importance of the clinical psychologist is

* Reeves, Margaret—Training School for Delinquent Girls—p.343
early recognized, since by means of standardized
tests it was possible to determine which children
were able to profit by treatment and achieve a fairly
useful maturity, and which were definitely psychotic
or feebleminded. The clinic worked with those in the
so-called "normal" group over a prolonged period of
time, and provided those who were definitely handi-
capped with proper instruction in the public schools
or state institutions.

**Origin of Psychiatric Social Work.**

The next step was emphasis on the social
history of the individual and on the physical ex-
amination in order to interpret better the mental
examination, and to reach decisions as to causes
of the delinquency and treatment to change it.

Psychiatric social work as such came into
being through the efforts of Ernest E. Southard
and Mary G. Jarrett at the Boston Psychopathic Insti-
tute. Before this time there had been social
workers in connection with a few hospitals for mental
and nervous disorders. Among them the Neurological
Clinic of the Massachusetts General Hospital in Boston
(1905), Bellevue Hospital, New York (1905), and Man-
hattan State Hospital (1911). The Boston Psycho-
pathic Hospital, however, claims to have created the part that social work plays in the mental hygiene movement today and to have given to it the name psychiatric social work. The social service department of this hospital was first organized in 1910, though the director of the hospital recorded in his notes, "the need of a social service in the new Psychopathic Hospital became obvious at once when the plans were tentatively begun in 1909-1910, and the obvious need was expressed in so many words in the State Board of Insanity's report in 1910. So far as I can remember, space was reserved for social service in the very first plan from which the eventual plan was developed."

The Hospital does not claim any novelty or originality for the idea, however. Psychiatric social work has grown out of other forms of social case work. The psychiatric social worker is defined by Southard and Jarrett in *The Kingdom of Evils* as a "social case-worker who has had systematic instruction in the psychological factors underlying behavior and in the principles of physical and mental disease and their social aspects, and training in dealing with psychiatric cases". **One great aim of modern social work has been to build up character** but

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Southard, E.E., and Jarrett, Mary C., *The Kingdom of Evils*, p.331

Ibid., p.371
psychiatric social work attempts to accomplish this aim by more exact methods, relying upon scientific fact rather than upon common-sense or trial-and-error methods. It represents a new emphasis rather than a new function. The idea has always existed, but the economic needs, the needs for food and shelter, were more conspicuous, and therefore, have received first attention. Joseph H. Proskauer, of the Appellate Division of the Supreme Court of New York, in an address at an annual meeting of the Philadelphia Child Guidance Clinic, said, "About the last thing civilization comes to in the process of differentiating the various functions of development is the study of man himself, particularly in his mental and physical phases." We have certainly seen this to be true in the late development of specialized study of the human mind and emotions.

The aim of the social service department of the Boston Psychopathic Hospital was (1) to have a complete social history for each patient admitted to be used by the psychiatrist; and (2) to prepare the family for the patient's parole and help the patient to readjust to the outside world; and (3) to break down the existing prejudice against hospitals for the mentally diseased and bring about a broader understanding of mental disease.

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Because of the limited staff, however, it has not been possible even yet to carry out this extensive program. About one-fourth of the cases are referred for a social history which is necessary for a diagnosis, but on which there is no further social treatment. The cases admitted to the hospital are divided into two classes—"intensive" and "slight service". The "intensive" cases are those where the "social service attempts to assume responsibility for making a full inquiry into the social condition of the patient and his family and endeavors to secure the largest measure of social well-being possible for both patient and family." The "slight service" cases are those where "assistance is given without inquiry beyond the apparent facts or responsibility beyond the immediate service".

First School Emphasizing Psychiatric Social Work.

The need for trained psychiatric social workers was evident in the emergency created by the Great War. Those who had seen the importance of such workers in civilian hospitals realized the great need for them in army hospitals. At that time, however, there were only a handful of trained workers in the whole country. The Boston Psychopathic Hospital was making plans to enlarge

\[\text{\cite{Southard and Jarrett}}\]

\[\text{\cite{Ibid}}\]
its capacity for training in 1910 when it was found possible to combine with Smith College in an intensive course in theory and in a period of supervised practice which was being given at Smith. Similar courses were given as emergency measures in other schools in New York, Philadelphia, and Chicago. Smith College School for Social Work, however, was the first to place special emphasis on the importance of the psychiatric point of view. The value of such an approach was first demonstrated by the study of war neuroses, but it soon spread to other fields.

"Social workers having this point of view and method of approach were eagerly sought for at first in hospitals and residential agencies; more recently an even more insistent demand has come from the field of preventive mental hygiene workers in clinics and schools. The psychiatric social worker has become an integral part of the psychopathic hospitals and child guidance clinics and is a valuable colleague in the preventive work undertaken by the courts and schools and in an increasing number of more generalized social agencies."

Clinic for Children at the Boston Psychopathic Hospital.

At the Boston Psychopathic Hospital just as at the Court in Chicago, it was soon realized that the most effective period for prevention was in childhood, and the period for treatment was gradually pushed backward from adulthood to adolescence, and to childhood. It was
recognized that children's problems frequently antedate the mental disorders of later life, and just as in physical diseases, the sooner the treatment is started, the better the chance for recovery. In 1919, the Boston Psychopathic Hospital opened a clinic for children. Their interest was based on their own discoveries, and they claim that it was entirely independent of the Chicago movement. The clinic made a thorough study of the child, including psychiatric, psychological, and social examinations.

The Psychiatric Clinic as a State Project.

In 1914, two years after the organization of the clinic in Boston, the Juvenile Psychopathic Institute in Chicago was taken over by Cook County, and the new changed to Institute for Juvenile Research. In 1917, this institute became an integral part of the Division of Criminology which is included in the Department of Public Welfare of the State of Illinois. During this same year Healy went to Boston to carry on his work there with the Juvenile Foundation and Hermann Adler became the Director of the Chicago Institute.

Trend During This Period.

The emphasis was still placed upon the connection with the Juvenile Court but the trend was toward the treatment of more normal children. Just before this time Healy had written:
"It would be much better in my opinion not to call this a Psychopathic Institute. Of problems studied, many are not at all psychopathic, nor do we commit ourselves at all to the idea that all problems of conduct belong in the realm of psychopathology."

Some of the larger and more important clinics opened during this period besides the one already discussed were:

Neue County Psychopathic Clinic, Detroit, Michigan, Opened February, 1910.

Judge Baker Foundation Clinic, Boston, Massachusetts, Opened April, 1917.

Juvenile Court Clinic, Los Angeles, California. Date of opening not given.

Children’s Court Mental Clinic, New York City. Opened January 1, 1917.

Municipal Court, Neuro-psychiatric Branch of Medical Department. Opened 1919.

Westchester County Clinic Department of Child Welfare. Opened 1917.

All of the clinics established during this period except the Judge Baker Foundation were supported by public funds. Though the emphasis was placed on the connection with the court, some of these clinics accepted a few other children for examination and treatment. Statistics from the Judge Baker Foundation show the trend during the period from 1917 to 1921.

** Ibid. pp. 206-207
"Of the first six hundred cases studied, 339 were sent by the Juvenile Court. Of the second and third groups of six hundred, the numbers sent by the Court were four hundred eleven and two hundred ninety-two. In 1930, children were referred to the Foundation by thirty-one different agencies.

"The proportion of children of normal intelligence examined increased although practically all of them had problems of misconduct. For example, in the Judea Bilar Foundation in 1930, of three hundred sixty-four children examined, two hundred sixteen, or 59.3%, were normal, and thirty-one or 8.6% had superior intelligence."

Research:

Research has accompanied the work of the clinics; because not only was it necessary to add to the store of scientific knowledge in order to develop better methods of treatment, but also it was necessary to educate the public. The degree of success of clinical service depends largely upon cooperation of the community at large. The work can not be handled alone. There is a definite need for a change in the fundamental attitude toward the administration of law and intelligent people must be made to understand that psychiatrists and penologists are doing a work which is based on scientific fact and not mere sentiment. Somewhat the same thing is true in clinics in connection with hospitals. The prejudice against hospitals for the mentally diseased must first be broken down and the public must be taught to accept mental disease as it accepts physical disease and every effort made to prevent it.

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Ibid., p. 203.
Both in the field of delinquency and in the field of mental disease, a vast amount of data has been accumulated, and used to enrich our knowledge of these subjects, which has also had an effect on education, social work, and judicial procedure.

In 1925, Healy published his pioneer volume, *The Individual Delinquent*, which is based on the study of one thousand repeated offenders, and sets forth the results of his work with them. It gives the methods of diagnosis, the causes and types of criminality and suggestions for treatment. Most of the cases are of young offenders around the ages of fifteen or sixteen. Healy says that he has chosen this age group for the sake of learning the structural growth of whole delinquent careers. He states that “to ascertain from the actualities of life the basic factors of disordered social conduct has been the deliberate plan of our work.”

Healy has published a number of books dealing with various phases of his work. In 1926, Healy and Augusta F. Bronner, who has been associated with him from the beginning, published a volume comparing and estimating their work in Chicago and Boston. This book, *Delinquents and Criminals*, was based on a group of case studies of juvenile repeated offenders in both cities. For statistical analysis they used four

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thousand cases consisting of two thousand offenders studied in Chicago between 1909 and 1915, and two thousand studied in Boston between 1917 and 1923. This volume "contains one of the best scientific work yet undertaken in the analysis of the causes of crime." *

The need for research has also been met at the Boston Psychopathic Hospital by the publication of The Kingdom of Eills by E. E. Southard and Mary C. Jarrett. This volume is also based on case studies, but the patients as a whole are older than those dealt with by Nally because it deals with those who have already become definitely psychotic. Southard analyzes each case and shows what can be done in the way of treatment. One of the primary purposes of this book is to show how social workers and doctors can cooperate in the care of the mentally deranged. The war-cry in this volume as well as in the works of Nally is individualization.

* Haynes, Fred. E. Criminology p. 49.
CHAPTER IV.

COMMONWEALTH FUND PROGRAM FOR THE

PREVENTION OF DELINQUENCY

As has already been stated, one of the chief functions of the National Committee for Mental Hygiene was stimulating the establishment of mental health clinics. At first the attention of these clinics was centered upon the treatment and prevention of mental disease and of delinquency because these were pressing public problems. The National Committee soon realized, however, that the work the clinics were doing was almost entirely remedial rather than preventative and plans were made to enlarge the scope of the work.

Brief History of the Commonwealth Fund and the Program Adopted in 1923.

In 1913, the Commonwealth Fund had been established by a gift of approximately $10,000,000 from the late Mrs. Stephen V. Harlans. Subsequent donations from Mrs. Harlans increased the endowment to approximately $30,000,000. The gift was to be used "for the
welfare of men". From the first, this fund concentrated mainly in the fields of child welfare, health and education. Through the National Committee for Mental Hygiene, the Board of Directors became interested in a program for the prevention of delinquency. They realized that this task was large, and to be comprehensive must include housing, eugenics, preventive and educational health work, industrial conditions, organized recreation and many other things. "The Commonwealth Fund sought a method whereby its efforts might be applied at certain strategic points, in the hope that these efforts might lead to the increase of resources readily available to workers in the field." The program adopted by the Board of Directors of the Commonwealth Fund on November 9, 1921, provided for the joint endeavor of four social agencies, organized in four divisions.

These were:

I. New York School of Social Work— for training workers.
II. National Committee for Mental Health— for establishing Child guidance clinics.
III. Public Educational Association of the City of New York— for providing Visiting Teachers.
IV. The Joint Committee on Methods of Preventing Delinquency— for unifying methods and objectives.

"American Foundations for Social Welfare", p.44
"Commonwealth Fund Program 1923", p.1
This program was to last for a period of five years and was aided by appropriations granted periodically by the Fund. The purposes of each division as set forth in the statement of the Program for Prevention of Delinquency-1923-were:

Sec.1-"To develop the psychiatric study of difficult, predelinquent, and delinquent children in the schools and the juvenile courts; to develop sound methods of treatment based on such study; and to provide courses of training along sound lines for those qualified and desiring to work in the field."

Sec.2-"To demonstrate in a number of widely scattered cities the value of such psychiatric study and treatment applied to children of this sort referred from juvenile courts, schools, and other agencies."

Sec.3-"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."

Sec.4-"To extend by various educational efforts the knowledge and use of these methods."

We are chiefly concerned here with the first two divisions of this program, those conducted by the New York School of Social Work, and the National Committee for Mental Hygiene, and the last one conducted by the Joint Committee on Methods of Preventing Delinquency.

Ibid, p.3.
The first of these administered by the New York School of Social Work, provided special training for psychiatric social workers, visiting teachers, and probation officers, and was directed by Porter R. Lee. Because of the pressing need for trained workers a number of annual fellowships were granted to supplement the establishment of training facilities. The School offered a number of courses in mental hygiene covering a wide field. "The class work included a basic survey of problems of human behavior, of the biological and psychological foundations on which the practice of modern psychiatry rests, of the various abnormalities in the functioning of the mind and of methods of treating these disorders of personality and behavior. A special clinic at a state hospital for the insane gave students an opportunity to observe the behavior of the mentally ill and to study the approach of the psychiatrist in analyzing and dealing with these individuals. Another course presented social implications of mental testing. Students were given the opportunity to test theory through practice in group and individual testing, thus gaining from another angle deeper understanding of the problems of personality as met in casework. . . . The school believed that psychiatric social workers should know the field of social work as a whole and major students were therefore urged to include in their programs courses in social case
work, child welfare, and community problem."

In order to be able to divide the instruction between class work and practical field work and to strengthen the academic program, a psychiatric clinic known as the Bureau of Children’s Guidance was established. This clinic was devoted to the study and treatment of children presenting special problems. It was "Especially equipped to make thorough personality, psychological, medical, and educational studies of children referred to it, and at the same time to furnish adequate opportunities for case study and field work." 39

The Bureau of Children’s Guidance received its first child on January 27, 1928. It was affiliated with five public schools but also drew children from private schools, charitable organizations, churches, and day nurseries. The intake, however, was carefully limited from the beginning because the aim of the Bureau was to make the work thorough and to place special emphasis on treatment in order to demonstrate its full potentialities. Its fundamental purpose was the training of students and, therefore, children chosen for study had to meet certain very definite requirements. "First, they must illustrate a wide range of childhood problems in order to give students

39 Commonwealth Fund Progress Report 1926, pp. 108-11
39 Ibid, p. 9
broad training for their responsibilities in the field of case work after the period of training was over. Second, they must contribute to the assembling of material for teaching and must therefore involve a need for prolonged social treatment rather than for brief contact with the psychiatrists. Third, they must throw light on the background of current psychiatric issues since they were to furnish data for the publication of new scientific material in the mental hygiene field."

The Bureau was in operation as part of the Commonwealth Fund Program for a period of five years and during that time applications were received in behalf of 322 children. Of these 521 were carried by the Bureau for a period of sustained treatment. The sources of referral realized the children's problems, but did not feel adequate to cope with them without assistance. About one-fifth of the cases treated resulted in failure. This was due partly to the natural limitations of a staff of human beings, partly to the lack of adequate knowledge of human personality and methods of handling its problems, and also partly to the failure of parents, teachers, and others to cooperate with the Bureau in carrying out the suggestions for treatment.

The second division of the Commonwealth Fund

Ibid-p.13
Program, administered by the Division for the Prevention of Delinquency of the National Committee for Mental Hygiene, was devoted exclusively to the development of psychiatric work.

"The Division Administration Staff (was) primarily engaged in supervising demonstration child guidance clinics in cities which desired subsequently to establish under local auspices permanent child guidance clinics to serve the public schools, the social agencies, the juvenile courts, and parents dealing with children presenting problems of adjustment to home, school, or community. The purpose of the demonstrations (was) not only to show the contribution psychiatric study can make to the treatment of behavior difficulties in children but to work out the functional relationships of a child guidance clinic to these other agencies in the community, medical, educational, social on whose cooperation the effectiveness of the clinic's work must largely depend.

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"At first the work of Division II was concerned mainly with the study of children already under supervision of the juvenile courts. By properly directed methods of treatment it was believed that the social rehabilitation of such children and the consequent reduction of delinquency in the community could be definitely advanced. In practice, however, it soon became evident that work with children the present behavior problems would be more effective if the problem were recognized and dealt with before the behavior had become so serious as to necessitate some form of court action." 6

This meant that the clinics became more definitely community clinics, and the scope of the work was so broadened that the name, "Progress for the Prevention of Delinquency," was a misnomer and the term "child guidance" was more accurately descriptive of the work.

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Briefly stated, the objectives of the demonstration clinics were demonstration, education, and research. A convincing demonstration of the study and treatment of children with behavior problems would include the treatment of a number of cases in cooperation with other agencies, and the training of those qualified persons who wished to work with the clinic either as volunteers or as cooperative workers from other fields. The second objective, educational work in the community in the fields of psychiatry and mental hygiene, involved lectures, conferences and publications, and in some cases courses in psychiatry, psychology, and psychiatric social work in colleges and professional schools. The third objective, research into causes and treatment, involved the critical analysis of the work of the clinic itself by which better methods of study and treatment of behavior problems could be evolved.

Demonstration clinics were available only to the very large cities where it was possible to conduct a model demonstration. The prerequisites for such an enterprise were an intelligent interest sufficiently wide spread to assure stability; a local financial backing which was capable of carrying the program after the demonstration with a minimum annual budget of $35,000.00; and an assurance of community cooperation by all children's agencies. These agencies must be sufficiently developed to enable the clinic to work through them.
"In all the cases, the main goal is that of establishing the clinic firmly as an integral part of the socially organized community, giving and receiving service in smooth and effective working relations with other community agencies."

There were two mobile demonstration clinics under the direction of V. V. Anderson, each staffed by workers and necessary clerical help. Each of these clinics remained approximately a year in a city, and then moved on to another demonstration center.

Besides these two demonstration clinics, there was a field consulting service which "was available to cities large and small which, without being in a position to receive the larger demonstrations, still wished to go ahead in the development of their own clinics, and desired advice in the organization and operation of such enterprise." The staff remained in the community for three or four months and assisted in organizing the clinic, strengthening its relationships in the community and generally nurturing the undertaking until it was safely established. The community had to apply for the assistance and be able to provide a minimum budget of $15,000.00 for establishing the clinic permanently.

St. Louis, Missouri, was chosen as the place for the first demonstration clinic, from thirteen cities that made application. E. A. Bliss, a leader in mental hygiene activities in St. Louis and the State of Missouri, realizing the need for the study of behavior problems in the incipiency, and supported by representatives of social

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*Anderson, V. V. The Organization and Operation of Child Guidance Clinics. P. 14.*
agencies, the Board of Education, the late Vital W. Garrosche, then Judge of the Juvenile Court, and others, applied to the Commonwealth Fund through the National Committee for Mental Hygiene for help in the establishment of a Child Guidance Clinic to serve the various sources in the community that dealt with child welfare. In response to this request, "a survey was made to determine the forces available in the community that could be mobilized and coordinated in a cooperative movement to lessen delinquency and crime and aid the maladjusted," and on May 10, 1932, the first demonstration clinic was opened in St. Louis under the direction of Thomas J. Heldt.

Since it was thought that the Juvenile Court could supply most readily patients for such a clinic, it was first housed in the Children's Building of the Court where the detention home was lodged. It was later moved to the present quarters of the permanent clinic in the Municipal Courts Building. In August, 1932, during the period of the demonstration the Department of Public Welfare conducted a survey embracing a study of individuals and conditions in the Juvenile Detention Home, Bellefontaine Farms, (a correctional institution for boys), the City Jail, the City Workhouse Infirmary, the Mental Observation Ward at City Hospital, etc. In October, 1932, the results of this survey were published, and among other recommendations the committee created to study the problems urged a Child Guidance Clinic and sug-

* "The St. Louis Psychiatric Clinic." - Synergist -

gested the Department of Public Welfare as the most logical placement for it.

The Demonstration Clinic withdrew in November 1922 after six months in the field and the clinic activities were continued until May 1, 1923 through the efforts of Doctor Bliss and the support of a group of his associates.

"This was a trying period since it was necessary to convince the Municipal Assembly of the need of making appropriations for it. This was accomplished and on May 1, 1923, the Psychiatric Clinic (Child Guidance Clinic) became an organization in the Department of Public Welfare financed by municipal revenue."

Soon after the opening of the clinic it was realized by those active in the work that the golden time for correction of behavior problems is in their infancy, and a program for the education of the community for this purpose was undertaken. This was necessary not only because the whole idea of child guidance clinics was still new, but also because of the location of this particular clinic. The fact that the clinic was located in the court building and had started by dealing exclusively with court problems, made the parents and organizations dealing with minor behavior problems hesitate to refer their children since they feared contamination or approbrium from association in a court building. As a result of this program, the early prejudices were in a large measure broken down, and the use of the clinic by the community has steadily increased.

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6 Ibid. p. 2.
In July, 1924, the clinic was designated to conduct examinations for prospective pupils in the St. Louis Training School, a municipal school for the training of the feeble-minded. This part of their service continued until 1923, when the school assumed its own responsibility for examinations, which enabled the clinic to devote more of its time to the problems of children of higher level of mental capacity. At the present time "the Clinic accepts for study individuals up to the age of twenty-one years presenting behavior problems who are not frankly feeble-minded or suffering from frank mental disease. Above this age a limited number of adult court cases are accepted and parents whose children are under study by the Clinic are also at times included for study." The Clinic accepts no short service cases except those seen in City Courts where the examination by the Clinic is followed up by a period of observation in City Hospital.

About the same time of the St. Louis demonstration, the second mobile clinic of the Commonwealth Fund Program under the directorship of Lawson J. Lowrey, began a demonstration in Dallas, Texas. This lasted from February 15, 1923 until September 6, 1923, when a permanent clinic was established in that city. From the beginning of the enterprise there was close association between the clinic and the social agencies of Dallas generally. The rapid
development of public understanding was evidenced by the fact that out of two hundred and fifty children studied during the demonstration, one-third were brought in by parents.

The clinic was housed in a building adjacent to the hospital and the medical school of Baylor Medical College and provided by the college. The director of the clinic was made professor of mental hygiene in the department of neuro-psychiatry at Baylor, and lecture courses were also given at the Dallas Institute of Social Education, the Episcopal Diocesan Conference, and Southern Methodist University. In addition, addresses were made before various community groups.

Other demonstrations during the five-year period were held in Norfolk, Virginia, (January 1923-August 1, 1923), at the University of Minnesota for the cities of Minneapolis and St. Paul jointly, (October 20, 1923-November 1, 1924), in Los Angeles, California, (January 1, 1924-January 1, 1925), Cleveland, Ohio, (December 1, 1924-December 31, 1925), and in Philadelphia, Pennsylvania, (March 1, 1925-June 30, 1927). These demonstrations resulted in the establishment of eight permanent clinics, and only one failure. The clinic at the University of Minnesota was continued, and separate clinics were established in Minneapolis and St. Paul. The one failure was in Norfolk, Virginia, where the city authorities failed to make adequate appropriations for the continuance of the work.
The consultant field service assisted in the establishment of clinics in Pasadena, Richmond, Virginia, Memphis, Macon, Georgia, Milwaukee, and Baltimore. Here there were two failures, one in Memphis after three years work and the other in Macon.

Division IV of the Commonwealth Fund Program was the Joint Committee on Methods of Preventing Delinquency, organized for the purpose of the Program "to provide a coordinating agency for the program as a whole; and to interpret methods and results through publications addressed to particular groups and to the general public." This committee was originally comprised only of representatives of the various participating organizations, but as the work developed the committee was enlarged to include other members whose experience in special fields was valuable to the whole enterprise.

As a part of its coordinating service the Committee undertook to bring together personnel connected with the various clinics for the interchange of information and experience in order to work out plans for more uniform records and statistics, clearer definition of the type of child to be accepted, and "the establishment of a common working basis for the clinics as parts of a unified undertaking, which should facilitate effective

Commonwealth Fund Progress Report-1926 p.35
presentation of the progress achieved during the period of the Program. There was an information service which answered inquiries connected with the program. This part of the work was facilitated by the publication of pamphlets and other literature, but there was also need for counsel by special correspondence.

In the Commonwealth Fund Program for the Prevention of Delinquency (1923), the following statement was made in relation to their program:

"The Commonwealth Fund does not expect to reform the world. The definite measurable results of the Program for the Prevention of Delinquency may even be difficult to ascertain. But, if that Program shall succeed in even so small a degree in demonstrating the value of new methods of approach, and in pointing the way to that may be accomplished with the individual by the basing of adequate treatment upon adequate knowledge, the effort will have been worth while."

Results of Five Year Program.

The original five-year program of the Commonwealth Fund came to a close on July 1, 1927, and both the Commonwealth Fund and the agencies which had cooperated with it felt that the project had been somewhat more successful than they had anticipated.

The results of the whole program were briefly summarized in the Commonwealth Fund Annual Report - 1927, and are as follows:

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Training.
Commonwealth fellows receiving one year advanced work-- 70
Two year graduates in Maternal Hygiene-- 33
Bureau fellowship students-- 36
Total students taking field work at Bureau-- 203

Treatment of Children.
A total of eight hundred and twenty-two children have been received for study and treatment by the Bureau. Of these, five hundred and ninety-one have been carried through complete treatment.

No attempt has yet been made to estimate the results of the cases handled. It is realized, also, that statistical proof of results in dealing with so intangible a thing as human behavior is extremely difficult if not impossible. Nevertheless, some excellent criteria have proved practicable. The staff has studied carefully the results in one hundred and ninety-six cases selected at random, and reports its judgment based on this study as follows:

Successful -- -- -- -- -- -- -- 33
Partially successful -- -- -- -- 61
Failure-- -- -- -- -- -- -- -- 43

In sixty-one cases it has been possible to corroborate the staff judgment of the parents. The staff was slightly more conservative. The results of the two methods are:

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<th>Staff Appraisal</th>
<th>Family Appraisal</th>
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<tr>
<td>Successful</td>
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<td>Failure</td>
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The Bureau estimated that the treatment on the cases accepted during the latter part of its work show a greater degree of success, indicating a steady improvement in the technique and method of psychiatry and Mental Hygiene.
IX. National Committee for Mental Hygiene
Division of Prevention of Delinquency

1. Locally supported child guidance clinics were established following demonstrations in St. Louis, Dallas, Los Angeles, Minneapolis, St. Paul, Cleveland, and Philadelphia. One failure—Norfolk, Virginia.

2. Over four thousand children given clinical service in demonstration clinics; through contacts established in treatment of these cases many thousand persons have been brought into touch with the work.

3. Studies of groups of cases receiving treatment from the clinic staff or from cooperating agencies under clinic direction in two demonstration cities, show success partial or complete in 73.5 per cent of the cases in one city, and 61 per cent in the other.

4. Training provided in demonstration clinics has included:
   a. Psychiatrists and psychologists trained in work with children. All now holding important positions in clinical work.
   b. Students of psychiatric social work given training.
   c. Fellowship students of University of Pennsylvania Medical School given clinical training at Philadelphia demonstration.

5. Permanent clinics established through assistance from the consultant service in Panama, Richmond, Minneapolis, and Baltimore. Richmond and Baltimore received temporary financial assistance from the Fund. No failures—Memphis and Boston.

6. Lecture courses by psychiatrists, members of various demonstration staffs.
conducted in the medical schools of the following universities: Minnesota, Southern California, Western Reserve, Pennsylvania, and Baylor. Such educational work done by staff members in the demonstrations through lectures, classes for mothers, courses for parent-teachers associations, medical societies, etc.

**IV. Joint Committee on Methods of Preventing Delinquency**

Special instances of the service of this committee are the maintenance of a library of publications in the mental hygiene field, which has been at the disposal of all staff members; a monthly staff letter which has furnished information concerning progress of the program as a whole; a statistical service which has devised a uniform record system for all clinics and provided supervision in its operation; and an information service on child guidance and mental hygiene which has answered hundreds of inquiries for information from all parts of the world.

In its capacity as interpreter of the work, the Committee has served in two ways. First, by the preparation of publications by members of the staff concerning various phases of the work, and by arranging for the printing and distribution of reports, monographs, and books usually of somewhat technical character, prepared by various staff members of other divisions. Second, it has also provided through the staff and through special committees, an editorial and advisory service in the preparation of certain publications. Quantity production has not been aimed at, effort being directed rather at the soundest possible presentation. The Committee reported that one hundred colleges and normal schools in 1937 were using the committee publications, either as texts or as required reading.

CHAPTER V.

PERIOD FROM 1927 TO THE PRESENT.

Changes in the Commonwealth Fund Program.

By 1927, the efforts to develop a new social technique in the field of child welfare had passed through the pioneer and experimental stages, and need for "methodical development of teaching material and technical literature" was apparent. The Commonwealth Fund, which played such an important role in the second phase of the child guidance movement, modified its original activities to concentrate its attention on the training of well-qualified workers.

The first important change pertained to the Bureau of Children's Guidance. This organization was replaced by the Institute for Child Guidance, "a similar but somewhat more extensive undertaking," which serves as a field and training center in close connection with the New York School of Social Work, the Smith College School for Social Work, and the National Committee for Mental Hygiene. The Institute has undertaken a very difficult threefold program involving (1) the field training of personnel for child guidance clinics and

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*Commonwealth Fund Annual Report 1929, p.62
* Commonwealth Fund Annual Report 1927, p.34
mental hygiene service generally, (2) the treatment of a limited number of unadjusted children, and (3) the publication of its experiences in the form of technical literature. The emphasis during the first year was necessarily placed on the problems of organization, but since that time great strides have been made in the development of training technique.

The task of training psychiatrists, psychologists, and psychiatric social workers has proved to be extraordinarily complex because of the many factors involved. First, there is the child himself who "must be studied, protected from every preventable hazard of treatment, and carried through some constructive adjustment if that be possible." Then there are the agencies referring the children with whom relations "must be so intimate and flexible that children will be sent in sufficient numbers to meet the Institute's training needs when its students are most numerous, and withheld at times when the staff is depleted." The next consideration is the men and women in training. "They must have the opportunity to learn by actually giving professional service under supervision; they must be guided enough to protect the interests of the child, and left to themselves enough to develop initiative and judgment. They must be oriented in a new field where

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* Commonwealth Fund Report- 1928, p.68

** Ibid
team-work is indispensable, and to that end they often need to be weaned from too much individualism. They must be helped to grasp general principles so firmly that they can adjust themselves to the wide range of working conditions and organization affiliations which they will find when they go into active service. They must be eased through the strain of learning to handle explosive emotional situations, for these men and women who were once children may find their own past mirrored obscurely but painfully in the experience of some child under care. "An important factor, also, in this complex task, is the shifting body of students at the Institute. The students work at the Institute for not more than a year and in some cases for a shorter period. They come and go at different times according to their school schedules, and not only must the school contrive to carry on a consecutive treatment service for the children, but it must also give the students, during their brief period of training, "the essentials of a delicate technique and a subtle philosophy."

Another fundamental problem is how to instill in students the necessity for cooperation with other agencies. "It is necessary -- not merely to train clinic workers to care adequately for a child through their own efforts, but

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Commonwealth Fund Report 1933 p.63

Ibid p.54
to teach them when and how to devolve responsibility." In a city as large and complex as New York, it is difficult for the Institute to play this cooperative role in a normal fashion. To meet this difficulty, the Institute organized a consultation service through which a relatively large number of children are admitted for brief study and then referred to other agencies for the treatment suggested by the Institute staff.

Progress is being made toward improved methods of training and treatment by a number of research projects. Once each year an attempt is made to evaluate the results of treatment on cases which have been closed, and which were in contact with the clinic long enough to justify such an estimate. In 1930 a special staff unit was set aside to conduct research projects of a more general character, and other members of the staff are always encouraged to undertake individual projects.

Although the Institute was at first linked definitely to child guidance clinics, it has now somewhat broadened its training service. Less than half of the students who completed their training in 1930 and reported the positions they were holding were in child guidance clinics, visiting teaching, or formal psychiatric social work. Many were to be found in family or child welfare agencies.

This may be explained partly by the fact that during this

\[\text{Ibid}\]
period of depression, family agencies are having to increase their staffs while child guidance clinics are unable to do so, but there is undoubtedly a very definite tendency to value psychiatric training as an asset for all social workers.

The present depression has caused the Commonwealth Fund to decrease its commitments, and after careful study it was decided that the Institute for Child Guidance could be discontinued with the least damage. It was felt that existing clinics would be able to take over the task of providing field experience for students and that, therefore, an independent training would no longer be essential. The Institute will operate on a reduced scale beginning June 30, 1933, after six years of service.

With the close of the Fund's five-year program the Division for the Prevention of Delinquency (Division II) was succeeded by the Division on Community Clinics, also administratively attached to the National Committee for Mental Hygiene and supported by the Commonwealth Fund. Through this Division the Fund maintains its link with child guidance clinics throughout the country. It is staffed by a director, who is a psychiatrist and does part-time clinical work, a psychiatric social worker, and a research assistant. "It works through correspondence, office interviews, field trips, and conferences, and has at its disposal a limited fund for financial assistance to developing clinics. If the mixed metaphor be permissible,
it attempts to be both clearing-house and balance-wheel in the complex phase of social development. "With the support of the Fund, it serves as a central bureau for the field, guiding organization in the interest of good standards, checking all-considered developments, stimulating research, and providing consultation service as to standards of work and personnel."

The Division inherited the advisory responsibilities of the former Division on the Prevention of Delinquency with reference to the clinics established during the five-year program, and also the educational responsibility toward communities that are considering such an undertaking. The emphasis now, however, has "shifted from the organizing activity of the demonstration period to a conservative policy which often has the effect of delaying premature developments in communities where interest has outrun sound preparation."

The child guidance clinic is an expensive piece of social machinery and its success depends largely upon the cooperation of the community as a whole, and is definitely shaped and limited by the development of more general types of social work in the community.

An outstanding case of community guidance by the

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a Ibid. p.60  
** Commonwealth Fund Annual Report-1931. p.36  
** Commonwealth Fund Annual Report-1928 p.55
Division in that of New Orleans. In 1926, local leaders there asked for assistance in organizing a clinic. After a careful investigation the Division recommended "that the existing social work for children and families be strengthened before the city attempted a service which depended largely on a foundation of good case work." A survey of the local agencies by the Child Welfare League of America and by the American Association for Organizing Family Social Work (now the Family Welfare Association of America) was then invited by the community. This led to the reorganization of the children's and family agencies. A new application was made to the Fund by Tulane University. "A reinvestigation by the Division disclosed the existence of a firm basis of responsible interest both in the university and in the city, and a contribution to the first year's expenses of the clinic was conditionally offered. The conditions were set: The university assigned suitable housing for the clinic, an advisory board representing the university and the city was set up, and the university found more than half the initial cost of operation. Staff was then secured, the Division arranged a traveling scholarship for the psychiatrist who heads it and a period of study at the Institute of Child Guidance for the psychologist, and the clinic is now at work." 42

42 Commonwealth Fund Annual Report - 1929 - P. 71
43 Ibid.
During the year 1931 the Division gave consultation service to thirty-four established clinics and some financial assistance to two of these; advisory service was given forty-eight committees interested in establishing child guidance clinics; and has aided in obtaining personnel for thirty-two clinics.

The research assistant of the Division is engaged in studying problems of administration, and clinic procedures to meet rural and small city needs.

"Through a cooperative arrangement, the Division refers inquiries as to methods of record-keeping and statistical measurement to the research statistician of the Fund's Division of Publications, who has built up an extensive service in this field and has brought about a high degree of uniformity in clinic practice." 89

The Division of Publications succeeded the Joint Committee on Methods of Preventing Delinquency on December 1, 1927, and has proceeded along the lines of the Committee. The publication activities of this Division were divided to provide for "the preparation of studies from original source material, and the editorial handling of material produced by professional workers affiliated with the Fund." 90

89 Commonwealth Fund Annual Report 1931 p. 36
90 Commonwealth Fund Annual Report 1929 p. 70
91 Commonwealth Fund Annual Report 1933 p. 73
This Division was created primarily for the purpose of publication needs, but its scope has been widened for administrative convenience to include such related activities as distribution, statistical service, library and information service. The Division issues and distributes the Annual Reports of the Fund, the quarterly News-letter, and pamphlets and announcements dealing with various phases of the Fund's work. It also manufactures and sends out standard forms for the use of child guidance clinics. All of these things are distributed without profit, but on a business basis.

In 1931 "no less than three hundred eighty-nine educational institutions ---- ordered Commonwealth Fund Publications for text or reference use." This more than triples the number reported by the Joint Committee in 1927.

The Library, comprised of all the libraries scattered through the various offices of the Commonwealth Fund, and of the former Joint Committee on Methods of Preventing Delinquency, was established in December, 1927, and a competent librarian was employed in order to make the material available for use. The library serves two purposes: "one, of strictly library character, primarily for members of the Fund Staff; and the other an information service for those who make inquiries along the lines of the Fund's Work."
Growth and Distribution of Clinics.

In 1922 when the Commonwealth Fund entered the Mental Hygiene Field the existing clinics offering psychiatric service to children might almost have been numbered on the fingers of one hand. It is estimated that

"There has been a net increase at the rate of the equivalent of eight new full-time clinics a year since 1923, of which three per year have been actual full-time clinics."

The first directory of clinics for children was issued by the Commonwealth Fund in 1925, and by 1929, the number had increased sufficiently to warrant the publication of a second edition.

"Not only were more child-guidance clinics in existence but many general clinics had begun to emphasize the children's side of mental hygiene work. Separate days were often set aside for children and arrangements were made with other clinical departments and with outside agencies to cooperate on children's service."

The directory for 1929, however, was so inadequate that it was not possible for the writer to make complete tables of comparison between the number and types of clinics in 1929 and 1931. In the 1929 Directory, the clinics were not classified as to service for children.

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or for children and adults; and the number of staff members and the types of service rendered by them were not designated. For this reason, it has been necessary to base the statistics for 1939 given in Table I on the summary of the clinic situation given in the Survey for September, 1938. It is recognized that this is not an entirely accurate comparison, but it gives a general picture of the growth of clinics in the last three years.

**TABLE I.**

**TABLE SHOWING COMPARISON OF CLINIC SITUATION**

<table>
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<tr>
<th>Year</th>
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<th>Crew</th>
<th>Adults</th>
<th>Total</th>
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Table I shows that there are now eighty-seven more clinics with psychiatric facilities for children than there were in 1928. The number of three-fold clinics has increased by one hundred seventy-nine. There is a discrepancy here in the difference in the definition of three-fold clinic. The writer has used it to mean one staffed by a psychiatrist, psychologist, and social
worker (psychiatric, medical or general) whereas, in the Synergist, the term is defined as a clinic "using the services of a psychiatrist, psychologist, and psychiatric social worker." The term psychiatric social worker being used here to mean one who has been trained in a school placing special emphasis on this type of work.

**TABLE II.**

**SHOWING THE DISTRIBUTION OF CLINICS IN THE FORTY-EIGHT STATES AND THE DISTRICT OF COLUMBIA.**

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<th>TOTAL</th>
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There is a further discrepancy, however, which would serve to balance the first one, in that the 1928 statistics include traveling clinic service, and this

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*"The Clinic Situation" - *Synergist*, September, 1928− p.1.*
has been omitted in the 1931 figures. There has been a decrease in the number of clinics which do not have a complete staff, and while the same inaccuracies enter in here, the number of trained workers is increasing and these workers are being employed by clinics that realize the need for the three-fold program.

In spite of the increase in the number of clinics, the number of states without psychiatric facilities (seventeen) is the same now as it was in 1930. Of the thirty-two states that have psychiatric clinics now, there are only two in which all the clinics had three-fold staffs. There are six in which all are incompletely staffed, and twenty-four that have both types. (Table II).

In 1931, there was a total of five hundred fifty-seven (557) community clinics for children in the United States designated as either psychiatric or neurological. (Table III).

Of this number, two hundred eighty-one (281), or a little more than half, were staffed with one or more psychiatrists, psychologists, and social workers. New York leads the group with one hundred eighty-four (184) clinics, of which ninety-eight (98) have complete staffs.

Of the two hundred eighty-one three-fold clinics, one hundred forty-six of them are for children only, thirty-five full-time and one hundred eleven part-time. (By full-time is meant twenty hours or more each week). The services of the other one hundred thirty-five three-
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<th>General</th>
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fold clinics are available for both children and adults. Twenty-four of these are full-time and one hundred eleven are part-time.

These statistics show that the number of clinics offering psychiatric services to children is steadily and rapidly increasing in spite of definite efforts to slow up the speed in order to preserve the quality of the work. This rapid growth of the movement is very encouraging, but at the same time it is a serious proposition because of the lack of trained workers. The training of clinic workers takes a long period of time and it can not be done fast enough to meet the present demand.
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CHAPTER VI.

ORGANIZATION AND METHODS OF A TYPICAL CHILD GUIDANCE CLINIC.

Types of Problems.

We have explained what a child guidance clinic is and have traced the development of the clinic; next we will describe how the clinic works, something of the problems treated, and the methods used.

The problems of the child who comes into the clinic have become manifest in his behavior either at school, at home, or in the community. The symptoms by which these are indicated may be grouped as follows:

1. "Undesirable habits of infancy which have persisted into childhood, such as enuresis, masturbation, thumb-sucking, peculiar food fads, night terrors, and mannerisms of various sorts.

2. "Undesirable personality traits, such as extreme degrees of sensitiveness, exclusiveness, secretiveness, apathy, day-dreaming, imaginative and fanciful lying, nervousness, meekness, quarrelsome, lack of interest in school or of ambition, cowardliness, inability to get along with other children.

3. "Undesirable behavior, such as disobedience, bullying, destructiveness, cruelty, temper tantrums, defiance of or rebellion against authority, keeping late hours, seeking bad companions, sex activity, lying, stealing, truancy." *

These symptoms may be indicative of various problem situations, and it is the work of the clinic to search for

the causes of the child's behavior and try to help him make a better adjustment. This is done through the study of the whole child, by a staff of specialists working as a single unit. The staff of a typical child guidance clinic is composed of psychiatrist, psychologist, psychiatric social worker, and sometimes a pediatrician, though the psychiatrist because of his training is equipped to give physical examinations.

The Four-Study Plan.

The importance of the physical examination is fully realized because the great majority of all children present mild or serious physical defects which call for remedial effort. When the child comes into the clinic, he is given a physical examination, supplemented by laboratory tests. If a pediatrician is connected with the clinic, he has usually spent some time in a hospital devoting himself to the diagnosis and treatment of children's diseases. As a rule, any treatment found necessary in the physical examination is carried on outside the clinic.

The child is next seen by the clinic psychologist, who is usually "a college graduate with a master's or doctor's degree conferred for special work in psychology, particularly in the measurement of capacities, defects, and achievements." She has usually obtained some child guidance clinic experience through supervised volunteer

service, as an assistant in a clinic, or through specific preparation at the Institute for Child Guidance. The child is given various standardized tests to measure his mental and emotional development in comparison with other children of his age, to determine special abilities and disabilities, and to measure educational progress. These tests, however, should never be considered as constituting a complete diagnosis. All present scales or measuring rods of intelligence are imperfect, and the psychologist must take into consideration all the factors which may influence the accuracy of the test.

The case is then turned over to a psychiatric social worker who is "typically a woman who has graduated from college and taken special training in psychiatric social work at one of the schools giving special attention to this subject." She obtains a record as complete as can be gotten of the child's environment, the stock from which he springs, and the child's own developmental career.

"The social investigation made by a psychiatric social worker, differs from that usually made by other social case workers, in the special emphasis it lays upon facts related to the mental and physical development of the child himself; of his family; of his immediate ancestry; and of the personality and mental attitudes of the individuals who make up the world that surrounds the child. It seems to record the interplay of these personalities, and to find there as well as in the concrete evidences of care and neglect that the home affords, the causes of unhappiness and maladjustment."
This information is obtained by interviews with the parents, teachers, and others who have known the child.

The child is next interviewed by the psychiatrist who is typically "a graduate physician and has had several years experience in an active psychiatric service for adults, and has capped this with a year or so in a psychiatric clinic for children." In the light of the data obtained by the tests and the social history-

"the psychiatrist attempts to discover by the silence method, or by indirect questioning, the child's attitude towards himself and his various reactions to the family situation and to the school and community situations." He "seeks to get a picture of the child as a living and adjusting personality, of the child as a whole and not any special phase of his make up."

After the necessary information has been gathered and the child has been seen by the psychiatrist, a staff conference is held. This conference "is the unique contribution of child guidance to the field of mental hygiene." It brings together all of those who have worked on the case and fuses the separate examinations by specialists in several fields into one picture of the child and his situation. It involves the pooling of a number of points of view, and after the various examinations have been interpreted, cumulative factors are determined when possible and recommendations for treatment are made. These conferences are attended not only by those involved in the case work of this particular child, but also by other members of the staff. Sometimes also the family physician, visiting teacher, school teacher, 

or representatives from other agencies are present.

The treatment actually begins with the parents' first contact with the clinic and does not end until all examinations are completed. The treatment plan, however, is worked out in the staff conference, and shows what is to be done, then, and by whom. The bulk of the social treatment falls in the department of the psychiatric social worker, though interviews with the psychiatrist for both the patient and the parents are arranged when it is deemed expedient. Alternate measures are always included in the recommendations to cover the inevitable obstacles to the ideal plan. No plan of treatment is rigid, for to be safe, it must always be subject to change.
CHAPTER VII.

CHANGING PHILOSOPHY AND TECHNIQUES IN CHILD GUIDANCE.

We have traced the development of Child Guidance clinics from 1900 to the present, now let us go back and see the evolution of the treatment philosophy and social case work techniques in this field. Since this study has been made from the standpoint of a social case worker, it would not be practicable for the writer to venture in to the realm of technical methods used by the psychiatrist and psychologist, so this study will necessarily be confined to the field of social work as applied in the child guidance clinic. This discussion will include, however, the "psychiatric approach" to the problem by the social worker, and some mention of the contributions of psychiatry and psychology.

First, we must define what we mean by the "psychiatric approach." It means "the adaptation of one's methods of approach to a real knowledge of the person's needs." 4

The growth of the general psychiatric point of view has been

4 Reynolds, Bertha C. "The Psychiatric Social Worker"

Institute for Child Guidance Studies. P. 03
steady and rapid in the past two decades; and is not confined to the field of child guidance alone, but is the one aim of all modern case work.

The period from 1909 to 1914 represented the beginning of specialization, and also of emphasis on the individual. We have seen that in 1909 Healy started his work with individual delinquents, and that this work has continued and increased until the present time.

The war furnished an opportunity for observation of individuals from all levels of society under similar conditions and shifted the emphasis from heredity and economic environment.

"Psychiatric workers who had the experience of working with disabled ex-service men gradually became aware of the significance of early life experiences in relation to the individual's capacity for adaptation during the war and in the difficult post-war period." *

This further increased the realization of individualization of members of the same family. Biological and sociological concepts merged about this time, and taught that

"the methods of shuffling, distribution, and recombining the genes of parents insures that no child shall be like either parent in its genetic constitution, nor like any other child, with the probable exception of identical twins, derived from a single fertilized egg. In consequence of these genetic differences, the members of the family differ considerably in the way they develop; in the way they respond to a given environment; in their behavior under given conditions; in what we call temperament, mentality, character." **


**Urs. S. Jennings - quoted by Towe - Ibid, p. 90.
Modern psychology has also contributed to the social concept applied in this field. By means of specialized and standardized tests it was possible to demonstrate the individual differences in mental capacities of members of the same family.

The psychiatrist, because of his training, attempts to bring all of these things together and to assist in bringing about the recognition of behavior as

"reactive, adaptive and expressive of the way in which the individual is meeting a situation." ♦

The modern philosophy of child guidance, then, is the treatment of the whole child in relation to his environment. It takes into consideration a complete social history, including family background, environmental surroundings, personal history of the individual's development, health, habits, adjustment in school, interests, recreation, companions, and personality. The patient is given standardized psychological tests to determine mental capacities, special abilities, and disabilities, and achievements. On the basis of this information, the psychiatrist attempts to discover the child's attitudes toward himself and toward other individuals and situations in his environ-

♦ Allen, Frederick N. - Evolution of our Treatment Philosophy in Child Guidance, - P. 5.
ment. Behavior is coming to be looked upon as a symptom rather than a problem in itself, and as a definite effort on the part of the child to satisfy some fundamental need. By discovering this need, it is often possible to help the child meet it in a more socially acceptable manner.

"The enlarged understanding of the factors which lie behind conduct problems in bringing about fundamental modifications of the orthodox methods used by teachers, parents and others in handling children." The old approach was a direct attack upon the behavior of the child. This was done on a moralizing or reasoning basis. An effort was made to convince the child that his behavior was undesirable, and if this was not effective, it was impressed upon him by punishment of some sort. Emphasis was placed upon the more superficial aspects of the situation such as changing the neighborhood, housing conditions, economic factors or some of the more extrinsic factors of the environment.

The modern psychiatric method is an attempt at understanding the underlying causes of the behavior, and dealing intelligently with matters aside from, but related to, the behavior of the child. It is being realized also that in order to help the child work out his problem, the clinic must work not only with the child but also with the parents and other adults who are influencing the child. "Dynamis

Sayles, Mary B. *Three Problem Children* P.7.
psychiatry has gone through an interesting cycle, begin-
ginning with an interest in unraveling the genetic history of adult reactions, which in time led to a greater focusing on the child, with the idea of studying and preventing these adult problems in their incipient stages. And now we find ourselves going back to a more careful consideration of those adult reactions, which are so important in shaping the personalities of the children. The understanding and modification of such adult problems has become the focus of our therapeutic endeavors in the field of child guidance."

Interpretation of behavior, however, has progressed much more rapidly than treatment. It has been difficult to get away from the eradication objective. Attention centered around what the child is doing has frequently forced the psychiatrist or social worker to adopt the specific suggestion type of approach. Misinstructed parents want prompt relief and want specific instructions about what to do. The desire for maintaining a good contact often leads the workers to gloss over the more fundamental problems and attempt to change behavior by working directly with the child by means of step charts, systems of rewards, or semi-norising, and working with the parents on a habit-training basis. This method only provides the parents with another excuse for not facing those

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Allen, Frederick H. Op. Cit. p.3
problems of their own which bear a causal relationship to the behavior of the child.

An approach based upon this type of therapy often does more harm than good, and the mere fact that the child's behavior has been altered does not necessarily mean that the treatment has been successful. Doctor Allen, Director of the Philadelphia Child Guidance Clinic, illustrates this fact by the following case.

"An attractive German girl of good intelligence was running away from her at very frequent intervals. She had presented a picture of a very autocratic father who ruled the family with an iron hand, particularly this girl. A great deal of work was done with the girl, both in the clinic and outside in the way of providing more satisfying outlets in the form of dancing lessons, Girl Scouts, and so forth, and enlisting the interest of teachers. The direct work with the father consisted mainly in telling him that he was not allowed to do to his family in this country. Partly as a result of our interest and efforts, the running away stopped, but the home conditions remained unchanged. In place of the running away there was substituted a cynical, resigned, and withdrawn attitude, which we all felt was a more serious reaction than the more natural running away."

Curt Rosenow of the Institute for Child Guidance has compiled an experimental list of therapeutic measures (unpublished) and those are classified by Bertha E. Reynolds, as those that are "predominantly the effecting of changes in the environment, those that are predominantly the giving of understanding, and those that are..."
in the emotional relationship between the clinic staff member and the patient, or the person in his environment who is for the time, receiving treatment. No one of these could be considered as a successful means of treatment in itself, because they all go hand in hand. For the purpose of discussion, however, it will be clearer to take them separately.

The study of the child may reveal the need for more wholesome recreation and companionship, or there may be a conflict between the habits of reaction set up in the past and those demanded by the present. This may indicate changes in treatment at home or at school, because the child must adjust to the two environments. There cannot be a stereotyped method of therapy for any problem, however, because each child reacts differently and what is ideal for one might be unsuitable for another. The social worker, in whose field treatment through changes in the environment usually falls, must consider not only that changes are necessary, but also how these changes are related to the individual child. They must be ever alert to the child's reactions to treatment and change the methods when it seems advisable. "The therapy may consist in putting more opportunities into a rector environment, resources for health care, education, recreation satisfying work religious expression. It may consist in taking the irritations out of an environment, either by

Reynolds, Bertha C.- op. cit. p. 53
removing them or by changing the environment completely, as by placing the patient in an institution or a foster home. An entire change of environment is resorted to much less often than formerly for the behavior difficulties of children, partly because it creates many new problems, especially if the child has to be shifted back to his own home later on, and partly because growth of knowledge of mental hygiene has made treatment, even in the original environment, more effective." 

The second classification of therapy includes those methods that are primarily concerned with the creation of understanding and interpretation of the patient himself or to others, and the interpretation of his environment to him. All of us create, to some extent, a world of illusion about us, and part of what we call environment is really what we feel. It is the task of the worker to maintain a balance between this world of illusion and the realities in the environment. The psychiatrist and social worker work together and act as the interpreter to him (the patient) of the forces, both within and without himself, with which he has been blindly struggling. "so

Though we admit that interpretation is an important part of therapy, the methods of giving it are still in the formative stages. The social worker has fallen into the easy but often ineffective way of pointing out mistakes and
telling parents what to do. This may serve to increase the parents' sense of failure. The approach to be effective must be on a sympathetic and understanding level. This method of working out with adults of their own attitudes and relationships, as well as those of the child, is the objective toward which the field of child guidance is working. "The important thing seems to be not to give parents an interpretation of the situation that a staff has worked out, but rather to utilize this interpretation as a means of getting them to discuss and work out important factors themselves, and to give them insight only as it seems to fit in with what they have been able to work out and accept." 

The third group of therapeutic methods includes "those which have to do with the emotional relationship between the person in the case situation and the psychiatrist or social worker." This is the factor in treatment that is most difficult for students or for those who are new in the field. There is a natural tendency to identify oneself subjectively with one person in the case. This is liable to produce defensive reactions from other persons concerned. The success of the therapy depends, however, upon "the capacity to be objective with all the individuals in a situation and still give them the feeling that you are sympathetic and anxious to understand their point of view, and to maintain that relationship in an atmosphere of tension and friction."

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These three methods must be carefully interwoven in order to produce the most effective results. Environmental changes must be accompanied by interpretation, and the success of the interpretation depends upon the relationship between the interpreter and the persons in the case situation.

The artificial distinction between the duties of the psychiatrist and the duties of the social worker are gradually being smoothed out. It is realized now that the psychiatrist can no longer center in the child and leave the parents to be handled by the social worker.

"To treat the child effectively, the parents must be included in any plan; otherwise they may remain active irritants or prevent the child from developing emotional independence." *

Frequently the adults in the case are in need of therapy just as much as, if not more than, the child, and there has been an increased tendency in recent years to bring these to the psychiatrist. The social worker on the other hand is often able to do things for the child in his own home which could not be accomplished by a formal psychiatric interview. The staff of the child guidance clinic is made up of specialists, but it is a "specialization in which each person in the clinical unit works

* Here Letter of the American Association of Psychiatric Social Workers, Dr. I.
with every other for the most understanding treatment of the patient."s

A great deal of progress has been made in our point of view on child behavior, and in treatment of the problems and difficulties which arise. We are gradually formulating a therapeutic philosophy that will lead to a more wholesome relationship between adult and child. "Progress in the future will depend upon our ability to develop this point of view in all the community agencies that deal with the child, particularly the child who has deviated from socially acceptable forms of behavior." co

Reynolds, Bertha G. -op.cit.- p.49
Allen, Frederick H. -op. cit.p.10
CHAPTER VIII.

CONCLUSION.

It can be seen from this study that a great deal of progress has been made in our treatment of behavior problems in children. Psychiatry has emerged from the diagnostic and custodial field and is taking its place in the realm of prevention. Though our knowledge in this field is still limited, it is increasing, and clinics are receiving responsive cooperation from agencies, parents, teachers, and children. Child guidance clinics are becoming community necessities for though it is the aim of the clinics to spread the knowledge of mental hygiene so that minor problems can be handled by parents and teachers, there will always be the more deep-seated problems that will require expert study. By learning to deal with the problems effectively, we can look forward to the future with hope of an increase in the amount of human happiness, social and industrial efficiency, and the moral welfare of the whole community.
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