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A description of the casework services of the Flint child guidance clinic in 1950

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A DESCRIPTION OF THE CASEWORK SERVICES OF
THE FLINT CHILD GUIDANCE CLINIC IN
1950

A THESIS
SUBMITTED TO THE FACULTY OF THE ATLANTA UNIVERSITY SCHOOL OF SOCIAL
WORK IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF SOCIAL WORK

BY
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ATLANTA, GEORGIA
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CHAPTER I

INTRODUCTION

The practice of social casework for many years was considered to be almost solely confined to the field of welfare work. Even today there are evidences of this attitude as witness the fact that many layman inadvertently refer to case workers as either "welfare workers" or "relief people." However, continual development in social work resulted in its gaining increased recognition as a profession and its utilization of the contributions of other disciplines. Use was made especially of the findings of medicine, sociology, education and law. But as casework progressed so were other fields whose chief concern was the study and alleviation of human problems. Chief among these fields was psychiatry which in the last fifty years has made tremendous achievements due largely to the work of Sigmund Freud.

Prior to Freud's work, the main emphasis of psychiatry was the treatment of the mentally ill, the psychotics, those who had almost completely lost contact with reality. It was the work of Freud and the founding of his new science of psychoanalysis which took the main emphasis from the psychotic and focused it upon the neurotic, those who had disturbed, maladjusted lives and yet were able to maintain contact with reality. Freud was able to discover the unconscious and determine that its origin lay in the very early life of the individual, demonstrating that a person's future adjustment to life was based upon his relationship to his parents or parent figures in childhood. Here was more knowledge to be of use to casework especially since the emphasis in casework is to effect a better social adjustment, and an adequate social adjustment cannot be too well effected
unless the person for whom the adjustment is being sought is understood.

As a result of the new findings of psychiatry, there arose in this country the mental hygiene movement which led to the establishment of mental hygiene clinics on national, state and local levels. The purpose of such organizations was to bring about better mental health, on as broad a scale as possible, through public education, and to effect programs for the construction of new mental hospitals and the repair of old ones. In addition, such organizations accepted the responsibility for providing training scholarships for psychiatrists and psychologists. However, as time went on it became apparent that more preventative measures would be necessary to combat mental illness. Out of the belief that attention to maladjustment in childhood would contribute to healthier adulthood, arose the organization of child guidance clinics.

As social casework was profiting from the teachings of psychiatry, so too psychiatry in time, came to profit from the contributions of casework. It was found that such things as history taking and home visits could be done effectively by social workers thus leaving psychiatrists free to give more therapeutic services. It was Dr. Adolph Meyer who first developed the use of a psychiatric social worker in this country. In 1904, while director of the New York Pathologic Institute, he enlisted the services of his wife, Mrs. Mary Brooks Meyer, who helped him in research by taking histories and making home visits.¹

With the advent of the child guidance movement, caseworkers became directly integrated into psychiatric services, although their roles varied

¹Harry Lipton, "Psychiatric Social Work" (School of Social Work, Atlanta University, 1949), p. 5 (Mimeoographed).
in keeping with agency settings. In some, social workers merely took social histories, the more direct treatment methods being in the hands of the psychiatrists; in others, they worked with parents while the children were being treated by the psychiatrists and, in a few clinics they performed in the role of therapists. This latter role demanded an intensification, if not a change, in casework skills as social workers were no longer confining their services to persons in social situations but to children and parents with emotional problems as well.

Purpose of Study

The purpose of this study was to describe the role of the psychiatric social worker in the Flint Child Guidance Clinic in light of the purposes and functions as set down in agency policy with consideration of the theoretical concepts of acceptable casework practice.

The Constitution and By-Laws of the Flint Child Guidance Clinic listed the purposes of the clinic as follow:

(a) To diagnose and treat children from birth to the age of 16, or until they have finished high school, who present emotional, personality or behavior problems to themselves, their parents or the community.
(b) To counsel and aid parents.
(c) To work for the prevention of maladjustment of children through community education.
(d) To help children and parents by cooperating with social agencies and other community organizations interested in the welfare of children.
(e) To cooperate with the Department of Mental Health in the overall state plan for the prevention of mental illness.¹

Scope and Limitations

This study included the services of the psychiatric social workers of

the Flint Child Guidance Clinic as revealed through an exploration of what was offered under the clinic's categories of Diagnosis, Consultation and Treatment; services to other agencies in the form of consultative and diagnostic services; and community wide services of mental hygiene education. The study was made of the services offered in the year 1950-1951.

Method of Procedure

The method employed was mainly descriptive with some use of statistics. The case load of the psychiatric social workers was classified according to type of service rendered, Diagnostic, Consultation or Treatment as set forth in agency By-Laws. Case examples were used to demonstrate these three areas of service with special attention to the role played by the case worker in each instance.

In gathering this data, conferences were held with the psychiatric social work staff members of the Flint Child Guidance Clinic. Case material was selected by examination of the cases on file and the selection was based on the availability of data which most clearly demonstrated the role of the psychiatric social worker. Use was made of books, journals, pamphlets, articles and annual reports of the clinic.

Setting of the Study

The Flint Child Guidance Clinic, which began operation in September of 1946, is under the sponsorship of the Department of Mental Health of Michigan and is jointly supported by the state and Communities which it serves, including the city of Flint and Genesee, Shiwassee and Lapeer counties.

The state of Michigan provides three professional workers for the Flint
Child Guidance Clinic, and the community being served by this clinic is expected to provide financially for additional staff members through the medium of the Community Chest.¹

When this study was made, the clinic staff included a psychiatrist and a fellow in psychiatry. The psychiatrist was the director of the clinic. The remainder of the staff included three psychiatric social workers, a psychologist, a psychiatric nurse, two student psychiatric social workers, and a psychology student trainee.

The city of Flint has a population of 175,000 and is characterized by one industry, the automotive. This industry pays very lucrative salaries which attract people from all over the nation. To the writer, it seemed that the community had become a melting pot of peoples ranging from extreme illiterates, some of whom were just recently removed from incest practices, to college graduates and professionally trained people. It also seemed that everything within the city was geared to the automotive industry.

Added to the complexity of the population, it further seemed to the writer that there were too few recreational and cultural outlets for the adults. In addition, the people of Flint seemed to adhere to a material sense of values which manifested itself in such things as "keeping up with the Joneses" which ultimately placed added strain upon the population. All of these influences which help to produce emotional tensions and disorders and which directly or indirectly affect the children make the need for a psychiatric clinic even more imperative. When the setting of the community is seen in this light, it can be readily understood that the Flint

¹Ibid.
Child Guidance Clinic is challenged to assume a great responsibility as a community service.
CHAPTER II

THE PSYCHIATRIC SOCIAL WORKER IN THE FLINT CHILD GUIDANCE CLINIC

The services of the Flint Child Guidance Clinic casework department are determined, like those of all departments, by agency functions and policies. These services have a two-fold aspect, services within the agency setting and services within the community but as an agency representative. The Constitution and By-Laws of this clinic listed five purposes which have been previously mentioned. The role of the agency in carrying out these five purposes is along three lines: Diagnostic, Consultation and Treatment.

Diagnostic

This classification was defined in the Constitution and By-Laws as follows:

Diagnostic: The child and his situation have been studied in the whole or in part for an evaluation and possible recommendations relating to problems therein, but where the clinic has no active part in subsequent treatment of the case.

In making diagnosis it must be remembered that:

The diagnostic process in child guidance insists on a comprehensive picture of the situation, the person, and the person reacting to his situation, including those earlier experiences which have contributed so much to shaping his character.¹

Case 1

S, a nine year old girl, was referred to the clinic because of bedwetting and an inability to relate well to children her own age. From her mother it was learned that S was the middle child of three

adopted children and that the adoptive father, Mr. H, had been dead for over a year. At the time of intake S's bedwetting had decreased considerably but occurred now and then whenever she was under pressure.

Mother described the relationship between herself and S as being good but thought that S could not get along with her agemates because of her need to dominate in play. After discussing this further, worker thought that S's desire to have her own way was symptomatic of her basic insecurity. With some difficulty Mrs. H was finally able to accept it.

Because of the cessation of the habitual enuresis and due to the added insight gained into S's behavior, Mrs. H was rather relieved and better able to accept S's behavior.

S was seen once and was found to be an attractive child who had no difficulty in talking. Her mother's feelings for her were discussed and she was surprised to learn of her mother's positive feelings for her. She was able to accept her mother's inability to express these feelings.

No further contact was had as mother did not feel any more need for help.

In the above case, the worker's diagnostic functioning consisted of her evaluating the child's problem and the way in which the child was meeting this problem. The worker's effectiveness in making this evaluation was contributed to by her understanding and awareness of the problems inherent in ordinal position, the complexities of life faced by a mother who must suddenly assume responsibilities of providing and caring for children after the father's death, the demands for maturing which such changes in a family constellation often place upon the children, and the resulting readjustment which was demanded for all.

In this child we find anxiety expressed in regression to an infantile level, bedwetting, and an inability to extend herself to other children. Her additional quest for an infantile level of adjustment is seen in the fact that she felt accepted only when she was permitted to have her own way. S's enuresis and ordinal position give some clue to what might constitute the cause of her problem. Enuresis is usually the expression of a desire
for love. That S. should have this symptom and be the middle of three children is also significant because middle children must strive to equal the older ones and keep in advance of the younger ones. In the patient's instance this could have placed added pressure upon her resulting anxiety expressed by enuresis. Her desire for love seems to be borne out by the mother's inability to express positive feelings for her. This inability on the part of the mother might have been caused by her being so absorbed in the problems of caring for her family that she had no time to show S. the affection she desired.

It can also be inferred that the loss of the adopted father seemed to correlate with the creation of uncomfortable anxiety in this child. By implication it can be suggested that the adopted father represented to this child security and in his death this security was denied her.

It is of significance that S. was surprised to learn of her mother's positive feelings for her, a very positive factor in the case. This could have been a derivative of the oedipal period, the time when the child has sexually tinged feelings for the parent of the opposite sex and, due to these feelings, feels competitive towards the parent of the same sex. This competitive feeling tends to create within the child intense feelings of hostility for the rivalrous parent — which turns to fear as the child projects onto the parent his own felt hostility.

The worker's understanding of the above factors enabled her to discern the child's need for an external ego support and the mother's need for


2 Ibid., p. 143.
assistance in the development of insights which enabled her to give the needed security to the child.

Case 2

P., a ten-year-old girl, was referred to the clinic by the municipal court because of having been sexually molested by her stepfather's brother, an acknowledgedly disturbed person.

P. was the older of two siblings and lived with her mother and stepfather. Her natural father and mother had divorced a year previously and mother was then living with stepfather and his family.

The family situation was a very maladjusted one in which the stepfather was attached to his mother who in turn was competitive with Mrs. G.

Due to the crowded condition of the house P. was forced to sleep on a davenport alone in the front room. One night her stepuncle entered the house drunk and manually manipulated her genitals. A medical examination later proved this to be true. Stepfather's family sided with this brother in denying this and mother subsequently took the children to live with her own parents.

Because of financial reasons mother was forced to place the children in boarding homes. However, because they could not adjust to the new setting this was found to be unfeasible.

Two interviews were held, one with the mother in which the above material was elicited and the other with P. Worker discussed with mother the possibility of institutionalization. This suggestion was later carried out by the mother.

P. was interviewed and was found to be an easy outgoing child who had repressed the experience of this attack.

A recommendation was sent to the court to the effect that the children be placed in an institution and the court was also informed of P.'s adjustment following this experience.

In Case 2 the worker was called upon to determine the extent to which this child was traumatized by the sexual experience to which she had been subjected. The nature of the referral seems to imply that the referring agency desired the Flint Child Guidance Clinic to diagnose this child in order to discover any resulting pathology from the attack. This was done in order to treat the child if necessary and thereby avert any future disturbances. Hence, the referral was preventative in nature and the worker's functioning was geared accordingly.

It was most imperative for the worker to have discerned the extent to
which this child was traumatized because such experiences as that undergone by P. could produce "a precocity of sexual development and an urgent desire before there is a possibility of real gratification." The painful elements of this experience could have led P. to associate pain with all sexual feelings in the future.¹

The worker's evaluation of P. revealed that cognizance was taken of the fact that P. had a well integrated ego, as shown in her ability to repress this experience and remain outgoing and that acceptance and affection had been given by someone, probably from her mother.

However, there were factors within the case that could have caused disturbance; the parents were divorced, the child was separated from her natural father, she was required to adjust to a stepfather and a conflicted family situation in which they were living.

Divorce almost always adversely effects children as they may feel that they are the cause of their parents' not living together. Because P. and her brother remained with the mother, there was the possibility of this girl's becoming overly attached to her mother which would make difficult her future heterosexual adjustment. Evidently there was some disharmony between the real father and the mother which made for an unwholesome environment for the children. P. was also subjected to an adverse home situation within the stepfather's home. There was an overcrowded house; the stepfather was overly attached to his own mother and she in turn was competitive with P.'s mother. That P. was able to be outgoing and to have repressed the experience of the attack in the face of all of these factors

¹Ibid., p. 58.
attests to the integratedness of her ego.

The worker's functioning in this case demonstrated the unity of the casework process. The nature of the case challenged the worker to diagnostically appraise the situation as she interviewed. Treatment was present in that the mother found relief in telling her problems to a person in whom she could confide. The worker's suggestion of institutionalization gave the mother support in selecting a course of action to resolve the family situation.

The worker seemingly based her planning upon an evaluation of the positive relationship which existed between the mother and the children. The worker had the responsibility of planning what would be best for all. Her recommendation of an institutional placement for the children seems to the writer most sound. It had already been tested that these children were unable to adjust to a foster home. Their reaction seemed related to the fact that their past experiences within the home had not been satisfactory. Added to this is the fact that many children consider it a threat to relate to foster parents. Within their own minds they fear loss of love and retaliation from their real parents should they do so. Also, since the mother was unable to support them at the time, the only suggestion to be made seems to have been that of placement within an institution. Another factor to be considered in making that suggestion is that it would be much easier for an outgoing child such as P. to adjust to other children than to be forced to adjust to more adults. However, in determining the extent to which P. was disturbed as a result of her being sexually molested, the worker performed her primary responsibility since that was the reason for referral.
Consultation

Consultation: The clinic's services are given to any person interested in the case but where there are no actual contacts with the child.

Consultation is a service given to a person or persons, or an agency, when a problem is recognized and help is sought for that problem. Wherein consultation is concerned, the emphasis is upon the requesting source's recognition of a problem and a desire for help with that problem.

Casework — sees the client in his tangled social relationships, counsels with him so as to stimulate his maximum effort on his own behalf, fills in where his knowledge is lacking, his opportunities are meager and where his courage would fail without a relationship of confidence with an understanding professional person. 1

Case 3

The T. children, a boy of six and a sister two years younger, were referred by the Friend of the Court for clinical examination to determine how disturbed the children were and what arrangements could be made for them because of the divorce of their parents. Two interviews were held, one with the father and the other with the mother.

Father appeared to be a very egocentric person who focused the interview upon his own bodily ailments and mother's shortcomings as a housewife. He expressed a desire to have custody of the children charging that mother was most neglectful.

Mother expressed a desire to help the clinic evaluate the children's needs. She was studying to be a Public Health Nurse and was not able, at the time, to care for them and thus desired foster home placement "in which the children would receive the love and affection of foster parents who in turn loved each other." She thought this necessary as she and father had often fought in the children's presence.

The case was conferenced and a recommendation of foster home placement was sent to the Friend of the Court.

In the above case consultation, considerations were with the maturity of the parents and the emotional needs of the children. In this situation it was necessary for the worker to appraise the parents' ability to provide satisfactorily for the children in a home with them or to cooperate in the

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formulation of another plan for the children's benefit. Although the position of the parent in reference to planning for the children is extremely important, mental hygienists place a greater emphasis upon the significance of planning for the children themselves. This case challenged the worker to appraise the pros and cons of separation from both parent figures.

In her appraisal of the father, the worker would, of necessity, have had to consider the fact that the father was a very egocentric person who was excessively preoccupied with his bodily ailments. Mr. T. also tended to project the blame for the marital discord onto Mrs. T. without any consideration of his own role in the family situation. He verbalized a desire to possess the children but had no plan to offer whereby their needs would be met. It can readily be seen that Mr. T. was an immature person with possible neurotic reaction as manifested in his unrealistic proposals, his egocentricism, defensive projection and in his excessive bodily ailments. It can be safely concluded that the father was not the person with whom any planning should have been made.

Mrs. T., on the other hand, seemed to have been a much more mature person as shown in her recognition of the instability of their home, her suggesting foster home placement, and in her receiving training for a Public Health Nurse in order to better provide for her children in the future. Wherein the instability of their home was concerned, mother was able to say that it was the lack of harmony on the part of both herself and her husband that was responsible for the unhealthy emotional atmosphere. The fact that she recognized her own role within the situation without projecting the blame entirely upon the father was of itself a sign of much more maturity than was demonstrated by the father.
The worker's focus in this case was determined by the reason for referral, hence the need for her to remain apart from the marital situation and restrict herself to working with the reality situation at hand. The worker's responsibility did not include services to the family toward an adjustment to the marital situation.

It could be speculated that the T. children might have been disturbed although there is no mention of this. The unhealthy emotional atmosphere of the home, and the apparent immaturity of the father provided a background conducive to the development of disturbed personalities.

The suggestion of foster home placement for these children seems to have been a practical one. These children were of the ages when children do not adjust too well to institutions because they are still dependent upon the mother person for personal attention and affection which they would not receive in an institution. This suggestion was also practical in the light of mother's desire for the children to receive the love and affection of a foster mother and father who loved each other, thus the children would meet some unmet needs.

In Case 3, there is no evidence of the child guidance clinic playing any role other than that of Consultation. The clinic functioned within the limits of its responsibility by suggesting to the referral agency recommendations for the case; but, in keeping with acceptable methods of consultation, the method of carrying through the plan was left with the responsible agency.

Case 4

K., a two-year-old boy, was referred to the clinic by a city health nurse for an evaluation of his intelligence. From the mother,
it was learned that K. was the older of two children and was a full term breast fed baby. During pregnancy mother was in very good health being sick only once. Mother noted that K. did not progress at all and that the six-month old baby had surpassed him in performance and was by far more mature than he. K. was found to be Mongoloid. The worker interpreted the findings of the test to the mother and recommended placement in an institution for feebleminded children. In interpreting the test to mother he explained the fact that she was not responsible for her child's being feebleminded. He further stated that this condition could be caused by a number of factors and that its occurring in any family did not constitute any inferiority inasmuch as the phenomena happens in all kinds of families without any respect to the innate intelligence of the members of that family.

Here again the role of the worker was that of a consultant. However, the case as viewed from the role of the clinic could be labeled diagnostic. The worker had no contact with the child but only discussed the child's behavior with mother, arranged an appointment for her with the psychologist, and later interpreted the findings of the test to her. In this case, as in the preceding one, a referral was made to the clinic by another social agency desiring help for a client which that agency was not able to give.

In the above case, institutionalization was recommended for this Mongoloid child taking into consideration the fact that most parents will maintain goals and ambitions for such children out of proportion to their abilities to achieve. This leads to pressuring from the parents and creates anxiety in the child and ends in frustration to both. Further, it has been noted that the retention of severely retarded or subnormal children in the family provides blocks on the part of the parents towards having more children. In this situation, such might also have had a negative effect upon the younger child. Because of contact with the handicapped brother, the younger child might tend to restrict its own development by imitating the brother and on the other hand, may suffer a lack of attention due to the giving of most of the parental attention and affection to the
incapacitated sibling.

The responsibility of the worker was in helping the client accept the unpleasant reality of placing this child in an institution. In many instances, this is an extremely difficult task because of the guilt that parents of mentally defective and physically abnormal children often have. The guilt usually extends from the fact that these parents produce such offsprings and also from the ambivalence that they may have towards the children. Because of such factors it is usually imperative that social agencies give support to the parent in sustaining them during and after carrying through the unpleasant decision. Here again the responsibility of the worker did not include the method of carrying out the recommendation but ceased with the rendering of the recommendation in keeping with the parents' ability to accept.

Treatment

The Constitution and By-Laws of the Flint Child Guidance Clinic defined treatment cases as follows:

Treatment: A treatment case is one in which consecutive appointments are held either with the child or parents (or both) for the purpose of influencing the progress of the case.

Whenever, after studying a case, treatment seems indicated, certain factors must be taken into consideration. A person's own abilities and capabilities for change must be considered in the light of external circumstances with which he is confronted, as well as how modifiable he is, in relation to his environment and how modifiable is the environment, in relation to the individual. After these factors have been considered a plan of treatment can be formulated.

An adequate plan of procedure is one which determines just what is to
be accomplished with a patient and the general approach best adapted to this end and also what chances there are for success, what difficulties stand in the way, and how the therapist expects to deal with them, always remembering the patient's actual everyday problems.¹

In psychiatric casework the unity of the case work process is constantly present, as in other areas of casework. The casework process involves the constant application of fact finding, diagnosing, evaluating the client and his situation, and treatment planning, as previously mentioned, all through the medium of a relationship wherein the client feels accepted. The following cases were appraised and the worker's functioning considered in the light of these criteria.

Case 5

P., a fourteen-year-old girl, was referred to the clinic by the school because of truancy and failure in school. It was learned in the intake interview that P. was an adopted child who was told of her adoption when she was ten. Later, she learned of the whereabouts of her real mother and brother and visited them quite frequently. The subsequent onset of truancy was a shock to the adoptive parents who had adjusted to her as a quiet, conforming child.

P. was seen in six treatment interviews. She impressed the social worker as a confused girl with mixed feelings about her natural mother and adoptive parents. Although she had never been able to discuss anything with her adoptive parents, she found her real mother a person in whom she could confide and feel at ease.

However, she could not understand why her mother had given her out for adoption.

When P.'s natural father died, she was a year and a half old. Her brother, who was two years older than she, was given up for adoption along with her, because her natural mother could not support them by herself. A few years later the brother's adoptive parents died and he was returned to the mother. This was the basis for P.'s anxiety as to why she was not returned home as was her brother.

Therapy was aimed at helping P. become less confused in her feelings and toward enabling her to accept her adoptive parents and her mother as they were. She became able to accept the fact that she truanted because of her anger and resentment toward the adoptive mother.

She also responded to therapeutic encouragement to verbalize her feelings toward her adoptive mother, rather than to express them by truanting.

Due to the treatment interviews, P. was able to see that her adoptive parents had always loved her and wanted her but it was not until they were threatened by her wanting to leave them that the demonstrated it to her satisfaction. As the result of increased understanding, insight and demonstrated acceptance, P. was able to accept her adoptive parents, became less withdrawn and made more friends. She gradually improved until her truanting ceased altogether.

The adoptive parents, and the real mother also, were able to accept P.'s feelings for them. The adoptive parents became able to accept her spending weekends with her real mother and the natural mother contributed to her acceptance of the adoptive parents. P. in turn was able to make an adjustment to both family units.

The role of the worker in this case can readily be seen as that of a therapist, as defined by the clinic, in that consecutive interviews were held with the patient, as well as with significant persons of her environment for the purpose of effecting adjustment for all.

The psychiatric social worker's treatment plans were formulations in keeping with the diagnostic evaluation which took into consideration the reason for referral, the symptoms, and the dynamics underlying the behavior patterns of the child as shown in the symptoms and in the child's overall behavior. P. was referred by the school because of truancy and school failure. Heretofore, the adoptive parents were not aware of any difficulties or personality problems, although it was later brought out that she had always been withdrawn. That the adoptive parents regarded her as being "all right" is in keeping with our culture wherein the submissive and compliant child is regarded as the "good" child. It is usual for parents to consider nothing wrong with a child until he reacts negatively in a social manner.

Truancy as a symptom and not a syndrome in itself is considered a flight reaction, an escape from an unpleasant situation. The unpleasant situation from which the child flees may be in the school or it may be in
the home. In P.'s case it seems to be due to a combination of home factors about which she was unable to verbally express her feelings, finding truancy as an avenue of expression as well as a method of flight.

Another reason for referral was P.'s failure in school. In many instances school failure can be a result of limited intelligence. However, an intelligence test can clarify this. There was no indication that any intelligence tests were given to P. This seems to suggest that failure was more related to emotional blocking, personal problems, than to inherent intelligence factors. It has been seen that adolescents do poor work in school because of problems associated with their psychological and physiological changes as well as because of abnormal home situations.\(^1\) Here again is another clue to P.'s situation, that of a conflict concerning her parents, both adoptive and real.

Withdrawal is often considered abnormal and symptomatic of a deeper conflict. Usually parents who are very restrictive and inhibiting because of their own insecurities, prevent their children from expressing overt hostility. Children react to such situations in one of two ways; either they openly rebel against the restriction of the parents or they become submissive. On the other hand, there are children who are seemingly born with constitutionally weak egos or who may no longer be able to withstand the pressures from the parents hence they give in to their demands for meekness and become very submissive and compliant. Although there is no mention of P.'s adoptive parents being overly rigid and strict it can be speculated that they might have been because P.'s behavior seems to indicate this.

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The foregoing material, as has been mentioned, would of necessity, have had to be considered by the worker. However, these factors cannot be considered as separate entities but must be seen as a part of an emotional constellation, that is, P. must be seen as a whole wherein her actions are concerned and this would be the main diagnostic responsibility of the worker.

P. was an adolescent girl of fourteen who had been adopted at a very young age and was not told of this adoption until she was ten years old. These two factors, of adolescence and sudden knowledge of adoption, seem outstanding dynamics for understanding her behavior.

It has been said that adolescence is a period in which a person is expected to:

(1) effect on emancipation from his parents and family,
(2) bring about a satisfactory relation with the opposite sex and at least begin to make some solution of his love life, and
(3) effect an integration in his personality for mature responsibility.¹

These goals are considered not too difficult to be achieved if the adolescent's personality development has progressed fairly well.

Wherein adoption is concerned, it has been recommended by adoption experts that an adopted child should be informed at a very early age that he is adopted. This is necessary because the parents thereby tell the child the truth about himself thus avoiding future difficulties and trauma for the child by his learning from other sources at a later age that he is adopted thus causing him to loose faith in the adoptive parents.

After considering the above two factors the worker can readily understand why P. was a confused girl whose feelings towards her parents, both

¹Ibid., p. 278.
adoptive and real, are mixed. She was an adolescent girl who had been subjected to several traumatic events in her life. Her natural father died when she was a year and a half old and she was taken from her own mother and given to adoptive parents at a time when children are very close to their mothers. The adoptive parents obviously did not meet her needs for love, affection, understanding, and attention as indicated in her inability to confide in them and also her inability to express her feelings, especially those of hostility. Accompanying these factors was the added trauma that came with being informed at a very late age, ten years, that she was an adopted child. This could cause her to lose faith in her parents hence, another reason for her inability to confide in them. The last great traumatic event experienced by P. was discovering her real mother to be alive and living with her natural brother about whom she knew nothing. This could have created additional problems, her frustration at not being able to live with her own real mother whom she discovered to be a very warm person as well as the sibling rivalry engendered by discovering that she had a brother who enjoyed the love and affection that came with living with her own real mother.

In working with P. it can be seen that the worker set for herself goals of alleviating the immediate problems by helping the patient become less confused in her feelings toward her mother and adoptive parents. The worker's role in this case was that of a warm accepting mother figure in whom P. could confide. Insight was effected by the worker's interpreting P.'s behavior to her in the light of the present reality situation. The confinement of interpretations to the present reality situations was necessary because interpretations of etiological factors carelessly given
to an adolescent might result in unassimilated insight which would tend to lead her to easily act out her impulses. This is because adolescents are still in the process of character formation therefore requiring each new bit of insight to be thoroughly assimilated and new attitudes gained to be carefully experimented with.¹

The worker seemed to have functioned most adequately in that she was able to help the patient verbally express her feelings in lieu of acting them out and also in her use of the environment by attaining the cooperation of both the natural and adoptive parents. That the worker was successful in her endeavors can be seen in P.'s final adjustment to both family units.

Case 6

B., a twelve-year-old girl, was referred to the clinic by her mother because of nervousness and immaturity. Five treatment interviews were held with the patient.

B. was found to be a very attractive girl but one who was compliant and submissive. She expressed many fears and thought that she preferred her mother, who was actually her stepmother, to her father. Both parents seemed warm, although the mother was less permissive. B. thought that the other girls disliked her because she made good grades. At home she did most of the housework. She was the youngest of four siblings, the other three being boys. The boys would tease her and do damaging things around the house for which she took the blame because she disliked seeing them whipped and preferred to be spanked herself.

B. was helped to work through her feelings of inferiority which had resulted in compliant behavior. She was able to see that her agemates' dislike for her was a projection of her own and that they had actually reached out to her but she had rejected them. She was also helped to see that there was nothing wrong in her thinking of herself and, with her mother's cooperation and understanding of the problem, she was helped to emancipate herself.

In Case 6, as in Case 5, it can be seen that, in keeping with the clinic's definition of consecutive interviews with both parents and child to influence

¹French and Alexander, op. cit., p. 313.
progress of the case, this was a treatment case.

Again can be seen the necessity of preceding any treatment planning with a diagnostic evaluation. In the B. case, Case 6, the worker had strengths as well as problem areas upon which to make a diagnostic evaluation and upon which to gauge therapy. The problem areas in the case seemed to be B.'s compliant and submissive behavior, her expression of many fears which were not specified, her preference of her stepmother to her natural father, her projection of not being accepted by other girls, her ordinal position — the youngest of four children, the other three being boys, her masochistic behavior as depicted in her taking the blame and accepting the punishment for her brothers' misdeeds and the hostility generated by her brothers' teasing. The positives in the case were the warmth and permissiveness of both mother and father and the patients high intelligence level as shown in her school successes.

B. was a twelve-year-old girls entering adolescence wherein a recapitulation of the oedipal takes place. Her father's warmth and permissiveness might readily have contributed to her very ambivalent feelings towards her mother. Her preference for her mother over her father might have been a denial of her hostile feelings for her mother. In an oedipal situation there is always hostility for the parent of the same sex because of unconscious competition for the parent of the opposite sex. Because of this hostility, there is aroused in the child feelings of guilt which may need expiation.1 To compensate for this guilt, the child may repress the hostility he or she possesses and may resort to a reaction formation whereby

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1Ibid., pp. 77-81.
behavior opposite the real unconscious feelings of the child takes place. This may have well been the case with B. as she was very submissive and compliant even to the point of masochistic behavior, her suffering for the brothers' faults. Another point that could bear out B.'s feelings for her father and hostility for her mother might be her fears. Although not specified here, these fears could be of the nature of those occurring during the oedipal period as this is a time in which the child has many fears which in reality disguise his true fear, fear of the parent of the same sex because of the child's love for the parent of the opposite sex, and also fear of retaliation because of the hostility had for the parent of the same sex. Hence, B.'s behavior seems to indicate more and more a conflict over her unresolved feelings towards her father.

Another point for consideration by the worker was the fact that B. was the youngest of four children and that the other three were boys. Youngest children are often overindulged and because of this are very babyish.¹ This, as well as the father's permissiveness, might have contributed to B.'s immaturity. Because of her being the youngest, and a girl besides, it was quite possible that the older boys felt displaced by her thus bringing about their hostility towards her as manifested in their teasing. The teasing inflicted upon B. by her brothers might have caused another conflict within her. If she had repressed her hostility towards her mother then she had a considerable amount of latent hostility. She could have probably felt threatened by her brothers' teasing because by it her defenses against her latent hostility were threatened, hence, even more need for compliant

¹O. Spurgeon English and Gerald H. J. Pearson, Common Neuroses of Children and Adults (New York, 1937), p. 44.
and submissive behavior resulting in her taking the blame and punishment for her brothers.

All of the above factors contributed to B.'s conflict. However, these factors contributed to her emotional maladjustment in still another way which was important for the worker to be aware of. B., as has been mentioned before, was entering into adolescence which is a period which is also characterized by the adolescent's seeking independence. Because of the confused feelings had by B. and the guilt revolving around these feelings it can be speculated that she was afraid to emancipate herself, thus bringing about another conflict in a period which can be characterized by storm and stress.

Although no treatment plan was given, it seems that the worker set about on a course of insight therapy as shown in the interpreting of B.'s behavior to her. In making interpretations it can be seen that the worker limited them to the then present reality situation as shown in the worker's interpreting B.'s projection of dislike onto her agemates. However, ego support must have been a necessary part, as its use facilitates treatment, strengthening the patient's ego, enabling her to accept interpretations. Such support was demonstrated through the worker's helping B. to accept the fact that it was not wrong for her to think of herself. The worker seems to have used the positives most constructively by making use of the mother's cooperation and through that have helped B. to emancipate herself. It seems to the writer that the worker's use of the mother's cooperation was an indication of very good functioning. Much more was accomplished by

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means of this than would have had therapy been limited just to the interview sessions as therapy is never a substitute for adequate life experiences. In the light of this, therefore, the worker's use of interested persons in the environment of the patient brought about improved relationships within the case and was a most judicious use of resources.

As a result of therapy B. was no longer withdrawn and became much more outgoing. She further made an adequate heterosexual adjustment which was very important for an adolescent.

In the above three classifications of Diagnostic, Consultation, and Treatment the role of the psychiatric social worker in the Flint Child Guidance Clinic can be seen in the case examples given in each classification. The responsibility of the worker was to use casework skills to fulfill the responsibilities dictated by the definition of the classifications. This means that the unity of the casework process was always taking place in the workers' gathering factual material, making diagnoses and evaluations and giving help wherever and whenever indicated and in the manner best indicated, thus helping the Flint Child Guidance Clinic meet its community responsibility.
CHAPTER III

GROUP THERAPY

Another service that was offered by the psychiatric social work staff of the Flint Child Guidance Clinic in 1950 was that of group therapy. The clinic thought that the group approach might be an expedient form of therapy for the many children who were referred to the clinic from a nearby children's institution. It was also felt that the group might help the girls in their group adjustment and that it might overbalance the rigidity of this institution, that some of the children who would comprise this group might be helped with their personal problems if the need arose, and that the group would be given an opportunity to develop a relationship with a mother figure.¹ This group consisted of eight girls whose ages ranged from ten to thirteen years. It was initially recognized that because this venture had to be carried out by a caseworker with no training in group work, the results of this group experience would be opened to question, although it was felt that such deprived children would benefit from this much special attention, to some degree.²

Records were kept of the group sessions along with individual summaries of each child. The following are examples of entries or individual girls:

D. was very rejected by the group in the beginning. However, by the end of the year of contacts with the group she seemed to be much more accepted by them. For example, on one occasion, when S. was in

¹This was an all girls club led by a female worker, however, a boys group was held simultaneously by the clinical psychologist.

²Records of Melba Rogers, Psychiatric Social Worker of the Flint Child Guidance Clinic.
one of her depressed moods K. volunteered to take over the ghost role that S. had been playing and the other girls seemed to accept this fairly well.

K. was the most immature intellectually of the group and she did not enter into the discussions very much. She would isolate herself by going over to the doll house when the other girls talked about sex, for example. She responded well to the support which worker gave her and definitely seemed to be reaching out for a warm mother person. She was clingy in the beginning and this was lessened only to a small degree. By the end of the contacts she was able to show some belligerence. K. seemed to be particularly upset about her appearance. When she first joined the group her hair was short and straight. Later, however, the matrons at the home began curly it which covered up her protruding ears. She was able to discuss her appearance frankly once and when we were using the dictaphone machine at one time she noticed that I had given S. the nickname of Giggley and she suggested that I call her Big Ears. Up until this time that nickname had been very traumatic for her.

G. was a very placid child somewhat depressed and withdrawn but she was very well accepted by everyone. She gradually developed a very strong relationship with me and soon she was drawn out of her shell to some degree. She did discuss her foster home placement with me before she left.

Even in these limited comments, therapeutic effects of the group relationships are clearly manifested.

The following is the recording of the first meetings of this group.

The meetings were held in one of the clinic playrooms.

During the first few interviews the girls elected officers. Since all of the girls came from the X Home they were a natural group and solidified very quickly at the clinic.

S. ran the election and the following officers were elected: R., president, she was obviously very pleased at getting this office and rather confident of the fact that she would get it. S. became the secretary; this was the office that she wanted and she declined the presidency. R. became vice-president. She nominated herself. K., treasurer. K. was not elected treasurer first and S. campaigned for her and explained to the other girls that K. never got anything and that they had better vote for her and they did. F. was elected Sargent at Arms; she turned down the other offices that she had been nominated for. S. was the last person elected and she became the party planner. She was a little disappointed at not having been elected to some other office but she was pleased with this office.

The first meetings were held according to very strict parliamentary
procedure. The girls made up some very rigid rules about entering and leaving. The Sargent at Arms had to line them up according to offices that they had been elected to before they could leave the room at the end of the period also. She had to open and shut the door for any girls who left to go to the bathroom and so on. During the first meetings there was a great deal of screaming about keeping quiet during the business part of the meeting.

The worker had a couple of books explaining various games and activities for girls this age on hand and also some crochet hooks, knitting needles and yarn. The girls were interested in doing some work with the yarn, however, this was shortlived. They soon turned toward using the audograph machine and they wanted the worker to get some popular records for the phonograph. They sang on the recording machine and took turns in a fairly cooperative way. The older girls danced to the phonograph music.

As the girls became more comfortable with the worker they began having gripe sessions about the X Home. They particularly complained about the way the dining room was run saying that they did not like the food and that they did not like being forced to eat things that they did not like. They also complained of some of the individual matrons and said that some were overly strict and had violent tempers.

F. ran away from the home one night with two other children but was soon brought back and the other girls were very interested in hearing about this episode; this was the first time that they had been able to get together to talk about it since F. had been placed in isolation since her return. F. was pleased with the attention that she got but at the same time she did not think that she would do this again and the other girls did not think that they would run away either when they saw the huge commotion that was aroused at this episode.¹

Therapy in a group situation, as in the above, is based upon emotional reorientation which comes from the fact that the child experiences situations in which he or she lives and works with other children and comes into interaction with others which is both direct and meaningful, which modifies his feeling tones and habitual responses.² This group was exposed to activity group therapy wherein the children are allowed to act out their impulses.

¹Ibid.

and conflicts within the group setting with no emphasis placed upon unconscious tendencies nor acquisition of insight. The elements of major therapeutic importance were the interaction that took place between the children and their relationship to the therapist who was permissive and accepting.¹

The worker by her permissiveness and acceptance thereby assumed the role of a mother figure which was in keeping with the most important dynamic element operating within group therapy, that is, the recreation of a family setting in which the therapist assumes the role of a parent figure and the other members represent the patients' siblings. "As in the case in early family relationships, the siblings' competition is resolved through the process of identification and then mutual love and protection."²

The movement that took place within this group can be seen in the worker's final evaluation. The worker was of the opinion that a fairly good relationship had developed between the girls and herself, thus giving them an understanding confidante and aid in their group adjustment. It was further noted that during the last weeks the members of the group were much more willing to compromise with one another. They seemed to have received some help with adolescent and pre-adolescent problems, especially sex, and had learned to establish some of their own controls. When the group began, their rules were very rigid but were gradually relaxed, and more realistically achieved. They had decided among themselves that they would not talk when other people were talking during the business sessions and they would no


²Ibid., p. 301.
longer use the Audograph machine except when the worker was present. They also made a rule not to go into the worker's desk except when she gave them permission to do so. They found much cathartic relief through group discussions of their feelings about living in an institution.

One of the limitations felt by the caseworker in being effective in this work project was her limited knowledge of group dynamics. Another limitation found by the worker was the age grouping of these girls which she did not feel was too well planned. The difference in maturity was quite marked and created its own difficulties. However, in spite of the acknowledged handicaps the improved personal relationships in the girls, individually and as a group, seemed to justify any consideration which the agency gave to supplementing its more routine services to children in need.
CHAPTER IV

COMMUNITY SERVICES

One of the services of the Flint Child Guidance Clinic in which the psychiatric social workers play an important role is that of community mental health education. This is a very important service because mental health today emphasizes prevention and rehabilitation and is no longer concerned with pathology only. This was recognized by the Federal Government in the establishment of the National Foundation for Mental Health which is yearly provided with millions of dollars for operation. However, there should be wider interest in mental health on the part of the American public. That there is necessity for this is evidenced by the fact that in 1950 there were an estimated 600,000 people in mental hospitals. Added to this is the fact that many doctors and psychiatrists hold that of the physical complaints brought to physicians' offices approximately seventy-five percent are symptoms of neurotic disturbances and this figure is considered by some to be conservative. Hence, the need to enlighten the public in the nature of mental disease and the means of practicing better mental hygiene.

The program of this agency regarding community mental health education consisted of talking to groups who requested speakers, participation in programs such as aiding the Flint Youth Bureau in educating its counsellors, and assuming responsibilities in organization and fostering of organizations.\(^1\)

The following is a table of the community mental health education

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\(^1\)The Flint Youth Bureau is an agency that offers counselling services to Flint youth.
services of the Flint Child Guidance Clinic for the year of 1950.

Teaching Seminars

By Psychiatrists .......... 7
By Social Workers ........ 31
Total .......... 38

Participation of Staff in Professional Capacity

Attendance at Local Meetings (not as formal speaker)

Psychiatrists ............. 3
Psychologists ............. 0
Social Workers ............. 5
Total ............. 8

Attendance at Society Meetings (district-state-national)

Psychiatrists ............. 4
Psychologists ............. 0
Social Workers ............. 1
Nurses .................. 2
Total ............ 7

The teaching seminars refer to educational programs such as that offered to the Flint Youth Bureau. The local meetings involve participation in community activities with other social agencies. The Society Meetings include attendance at professional organizations such as the American Orthopsychiatric Association and the Michigan Mental Health Organization.

Another educational service offered by this clinic was that of school conferences. These were held for the purposes of understanding the school's concepts of the child, to furnish the school with additional concepts of childhood behavior, and to participate in making the best possible plans for the child such as suggesting the use of special rooms, placement to another school or removal from school.¹

¹Interview with Mildred Lauster, Flint Child Guidance Clinic, Flint, Michigan, February 19, 1951.
CHAPTER V

SUMMARY AND CONCLUSIONS

The Flint Child Guidance Clinic, which began operation in September of 1946, is under the sponsorship of the Department of Mental Health of Michigan. This clinic is a joint state and community agency and serves the city of Flint along with the counties of Genesee, Shiwassee, and Lapeer.

The Constitution and By-Laws of this clinic listed as its five purposes diagnosing and treating children from birth to 16 years of age who presented personal and emotional problems, offering counsel and aid to parents, community education for the purpose of preventing maladjustment of children, cooperation with other social agencies and community organizations interested in child welfare, and working with the Department of Mental Health for the prevention of mental illness. The role of the clinic in carrying out these five purposes was in three areas: Diagnostic, Consultation and Treatment.

This study proposed to describe the role of the psychiatric social workers of this clinic in the light of the aforementioned purposes and role of the clinic and also to view the workers' functioning according to approved casework techniques and psychiatric principles.

The clinic defined Diagnostic cases as follows:

Diagnostic: The child and his situation have been studied in the whole or in part for an evaluation and possible recommendations relating to problems therein but where the clinic has no active part in subsequent treatment of the case.

In the two case-examples given in the Diagnostic classification, the workers' role of fact finding, evaluating and making recommendations in the light of the factors present could be clearly seen. It was further demonstrated that the psychiatric social workers of this clinic were adept at
interpreting behavior to patients in acceptable casework fashion, in a manner acceptable to the patient. The diagnostic skill of these workers was manifested in their ability to discern significance in the factual material given.

The Consultation case examples also showed the adequacy of the workers' functioning. This classification was defined thusly:

Consultation: The clinic's services are given to any person interested in the case but where there are no actual contacts with the child.

The examples demonstrated within this category were typical consultation cases in that they were referred to the clinic by other social agencies due to the inability of the referring agencies to adequately fulfill all of the responsibilities demanded by the case. In meeting agency responsibility in this area the psychiatric social workers functioned according to standard consultation techniques in that they ascertained the client's problem through learning of his concepts of it, learned of any solutions to the problem that the client might have had and evaluated client potentialities and made realistic suggestions to the client and the referring agency. However, the workers further demonstrated their ability to handle consultation cases by leaving the methods of carrying out any suggestions made by them to the referring agency with whom this final responsibility lay.

In the Treatment classification which the clinic defined as follows:

Treatment: A treatment case is one in which consecutive appointments are held either with the child or parents (or both) for the purpose of influencing the progress of the case, the workers' use of unified casework process techniques was clearly evident. The workers were called upon to diagnose and treat according to their diagnoses. In the formulation of diagnostic evaluations there was speculation as to the facts of diagnostic significance which would have to be considered and the
workers' methods of therapy were analyzed. It was found that they used insight and supportive therapies rather adequately in that they displayed an ability to use support and insight when indicated. In their use of insight therapy, these workers were seemingly quite capable at limiting interpretations to present situations when deemed feasible, and also when interpretations should have been made in the light of developmental factors, the patient's relationship to the significant adults in his childhood.

The psychiatric social workers were called upon to act as group therapists because it was felt by the clinic that the group approach might better meet the needs of some of the children coming to the clinic. Despite the worker's feeling inadequate due to a lack of group work training, it could be seen through an examination of the individual summaries and records of group sessions that personality changes were brought about and that the children comprising the group were better helped in their group adjustment.

Because the Flint Child Guidance Clinic is a community clinic, the psychiatric social workers were called upon to work for the prevention of mental illness through mental health education. This was effected through teaching seminars, lectures and attendance at society meetings of national and local scope. Members of the psychiatric social work staff taught counselling and other techniques to the workers of other social agencies dealing with children. Lectures consisted in meeting with social and civic organizations for the purpose of informing such groups of mental hygiene practices involved in the rearing of children. The social work staff attended society and other professional meetings for the purpose of enhancing their knowledge in order to offer more and better service to patients and clients. Through such means professional development and growth were facilitated.
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